CLEARINGHOUSE

MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

"BEST PRACTICES" CASE STUDY: MARYLAND MEDICAID PROGRAM

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"Best Practices" Case Study

Maryland Medicaid Program

A Descriptive Review of Exemplary Program Options

Prepared Under SRS Contract No. SRS-500-75-0004

by

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PREFACE

This report is one of a series of "best practices" case studies prepared by General Research Corporation and its subcontractor SysteMetrics under contract to the Office of Planning, Analysis and Evaluation, Social and Rehabilitation Service, Department of Health, Education and Welfare. These case studies are part of a larger effort by General Research Corporation and its subcontractor SysteMetrics to assist DHEW in the analysis of the fraud and abuse control activities nationwide in Medicaid and Aid to Families with Dependent Children programs. Other activities include a nationwide mail survey to collect baseline data on fraud and abuse control efforts in all states and an analysis of the options available to the Federal government to further enhance fraud and abuse control in these programs.

The "best practices" case studies are based on visits made by GRC/SysteMetrics staff to selected states which appeared to constitute the best examples of fraud and abuse control programs. The primary objective of this effort is to determine what procedures and practices that the selected states are using appear to be effective and worthy of replication in other jurisdictions. Each state is individually reported in this case study format and from this data base a final analytic report discussing the relative value of the exemplary practices seen in all states will be prepared. The states to be reported in this series include:

Medicaid	AFDC
California	Maryland
Maryland	Massachusetts
Massachusetts	Michigan
Michigan	Minnesota
New Jersey	New Jersey
Ohio	Ohio
Oklahoma	Pennsylvania
Pennsylvania	Washington
Washington	Wisconsin

The states were selected in conjunction with DHEW personnel and represent those states which appeared to represent a mix of practices of interest to the study and which were suitable for site visits at the time of the study. Therefore, these do not necessarily represent the "best" nine states with respect to fraud and abuse control in each program but are certainly among the best.

Fraud and abuse control is an integral part of maintaining program integrity and increasing the quality and efficiency with which the program is administered and program goals are achieved. It is essential that fraud and abuse control procedures not be viewed in isolation from other program elements, but should be recognized as being part of a series of steps which states can take to improve the operation of their programs and reduce costs incurred through the misappropriation of program funds. Therefore, in the course of conducting this study and in developing the case study reports, fraud and abuse control efforts have been defined to include all systems and procedures which impact fraud and abuse prevention, detection, investigation, administrative actions, prosecutions and recovery. The case studies are organized to report each state's activities in these functional areas in the initial chapters. The authors' opinions and analysis have been reserved for the final chapter on best practices. The best practices chapter is designed to discuss conceptually how and why procedures reported in the initial chapters are exemplary and may be suitable for replication in other jurisdictions. Therefore, the best practices chapter discusses the pros and cons of such practices in various settings and is not directly a comment on the state reported, but rather an analysis of the practice per se and how the reported state exemplifies the concept.

Finally, these reports are in no way intended to be evaluations of the states involved and General Research Corporation is deeply indebted to the states which so graciously participated and assisted in these studies through the contribution of their time, information, and ideas.

ACKNOWLEDGMENT

General Research Corporation and the author wish to extend our thanks to the staff of the Maryland Department of Health and Mental Hygiene, Medical Care Programs, who shared their time and information to assist in this study.

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MARYLAND MEDICAID CASE STUDY

I. PROGRAM OVERVIEW

A. Program Characteristics and History

The Medicaid program in Maryland, involving approximately 430,000 persons, is administered through two departments. The Department of Human Resources is responsible for administering the public assistance and social services programs involving approximately 340,000 persons in public assistance cases and for determining eligibility for the approximately 90,000 persons in medical assistance cases. This is done through a county administered structure. The Department of Health and Mental Hygiene is responsible for all other aspects of the administration of the Medicaid program. This responsibility is carried out through the Assistant Secretary for Medical Care Programs. The vast majority of recipients are located in the Baltimore and Washington metropolitan areas. Approximately 54 percent of all Medicaid claims come from Baltimore City. The budget for provider reimbursement is $261 million for FY77 and approximately 6.5 million claims are processed annually for payment to the program's approximately 8,000 providers.

Medicaid fraud has long been a concern in Maryland. This is illustrated by a letter from Attorney General Burch to Secretary Solomon of the Department of Health and Mental Hygiene in 1969 concerning the importance of the problem of fraudulent Medicaid providers. This letter is contained in Appendix A, the Maryland Investigative Manual. At the time of the letter (September 1969), seven providers had been prosecuted and cases against 11 more were in progress. Approximately $75,000 in restitution had been recovered by the state. Although the potential for program development which might result from such early recognition of the problem has not been fully realized, Maryland's provider fraud and abuse efforts pre-date those of most states in the nation and are characterized by a prosecution-oriented philosophy and excellent, if limited, investigation capability.

B. Program Administration

Under the purview of the Assistant Secretary for Medical Care Programs there are three organizational units depicted in Exhibit I-1:

- Policy (including provider education)

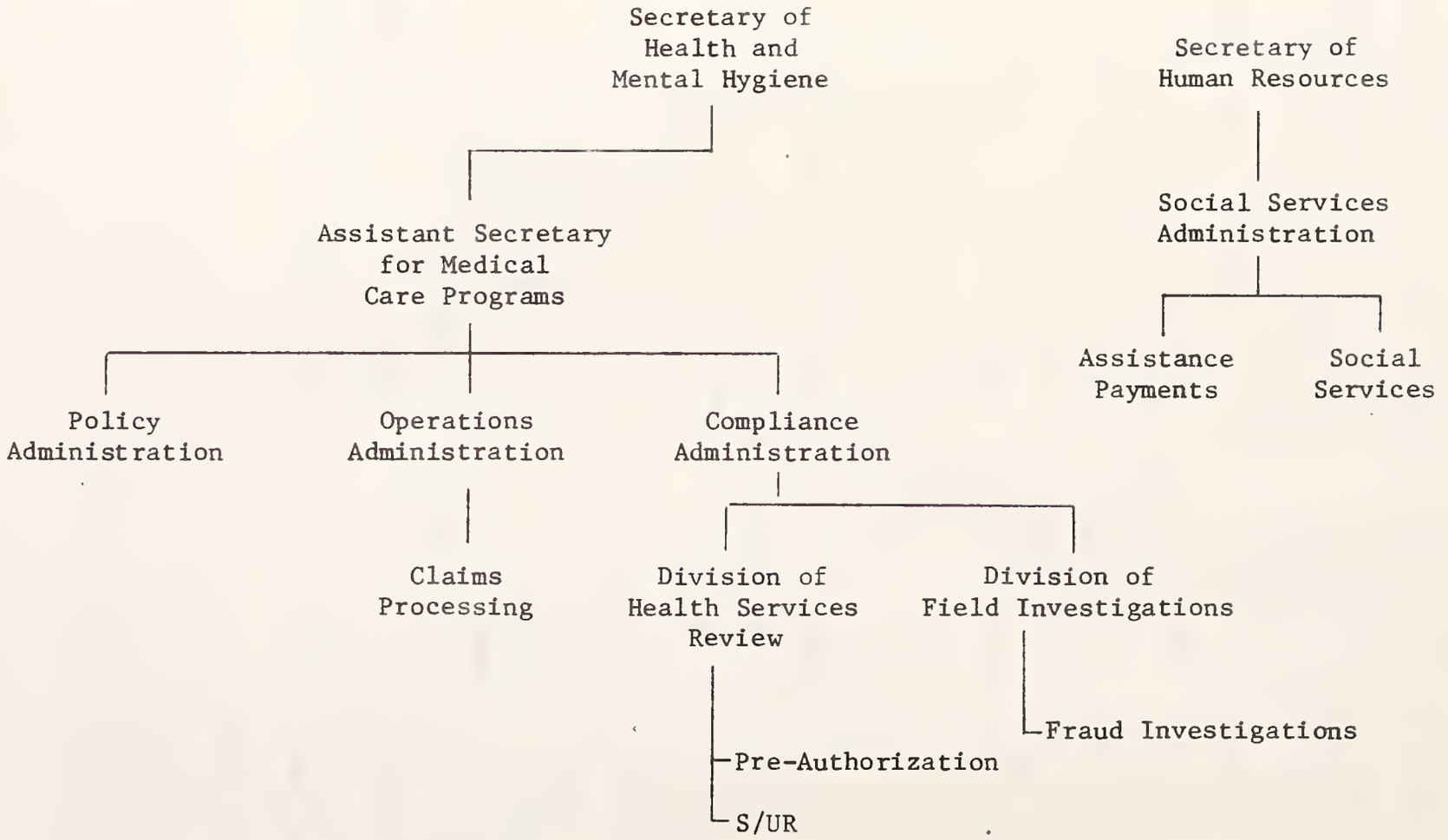

Exhibit I-1. Organization Chart

- Operations (including claims processing and provider certification)
- Compliance (including surveillance and utilization review and fraud investigations).

Each of these organizational units will be discussed in the context of the functions it performs as related to fraud and abuse control in the succeeding sections of this report.

For purposes of this report, the primary unit of interest is the Compliance Administration. Within the Compliance Administration is the Division of Field Investigations which is the provider fraud investigations unit. Within this unit also is the Division of Health Services Review which has program abuse control functions including pre-authorizations, and surveillance and utilization review.

II. PROVIDER FRAUD AND ABUSE CONTROL

A. Administration

There are 31 staff members in the Compliance Administration. Of these 10 are staff in the Division of Field Investigations, 14 are involved in health services review activities (including pre-authorizations) and seven are management and support staff.

The Division of Field Investigations is particularly important. It is headed by a former FBI agent who has been with the state for a number of years. His "investigators" receive starting salaries of $8200 per year. There are no educational or special training requirements for the positions. Because of the low starting salary, the Division Director has taken the position that he must hire individuals with apparent ability and expect to train them on-the-job to be investigators. To this end he has created a working draft of a field manual for his staff. This manual is an excellent example of this type of material and is presented in Appendix A. Particular items within the manual will be cited throughout this report and referenced as Appendix A. The manual contains a table of contents to assist the reader in finding particular items within the manual.

The Division of Field Investigations is responsible for investigations of both Medicaid provider and recipient fraud. The Division Director is also the coordinator/supervisor for public assistance recipient fraud for which the investigations are actually conducted by state police or the

Baltimore City Special Investigations Unit. This section addresses only his responsibilities as Division Director and with respect to provider fraud. For complete details on the organization of investigative activities with respect to recipient fraud, see Section III (Recipient Fraud and Abuse Control) and the GRC report on fraud and abuse control in the Maryland AFDC program.

The smallness of the unit is such that it can be personally supervised by the Director. The procedures are very much those of a thorough and reputable police organization. The reader is directed to the Investigative Manual (Appendix A) as a good statement of the character of this division.

B. Prevention

In the area of prevention, the traditional activites are conducted: provider certification, provider education, pre-authorizations, and claims processing. All of these activities, except pre-authorization, are conducted by the Operations Section of the Medical Care Program's Administration. There appears to be nothing unusual about the manner in which these activities are conducted except that provider education is apparently conducted only to a very limited extent and that the system of pre-authorizations (Maryland's terminology) is relatively new.

Pre-authorization was expanded on January 1, 1976. In addition to certain services requiring prior authorization before January 1, 1976 (such as cosmetic or experimental procedures), covered services now include:

- Non-emergency ambulance services
- Durable medical equipment
- Selected podiatry services
- Selected dental services
- Eye examinations
- Oxygen for home use
- Prescriptions over $20

All authorizations are handled by staff of the Division of Health Services Review in Baltimore, except for pharmacy services which are authorized by local health departments. Local health departments also make level of care certifications for nursing home services and provide the medical review teams which annually certify nursing homes.

Pre-authorizations, except for pharmacy services, are handled by mail or through toll-free telephone lines to Baltimore. Operators use a microfiche file to determine whether a claim has already been paid on behalf of the recipient for a service such as vision care, for example, which has a time frame limitation. Medical consultants review more complicated cases involving medical necessity issues either in response to telephone calls or written requests. Maryland staff report confidence in the value of pre-authorization as a control procedure.

In the area of rate setting, the state contracts with the Hospital Cost Analysis Service, a non-profit group which audits and establishes rates for both Titles XVIII and XIX in Maryland for inpatient facilities.

The Maryland claims processing system has much room for improvement; the state is currently in the process of installing the Medicaid Management Information System (MMIS) which will bring the needed changes. However, there are several interesting points about the current system.

First, since AFDC is county administered, and there is no single state file of AFDC recipients, the Medicaid eligibility data base is used by Assistance Payments staff for a variety of purposes, most notably wage screening.

Secondly, the current system has no duplicate claims checking ability. For the two fiscal years 1974 and 1975, the state recovered approximately $170,000 in payments later discovered to be duplicates and expects the total recovery level to be about $250,000 for this period. However, HEW auditors estimate the potential level of over expenditures due to duplicate payments to be $1-1.5 million. State staff report that these duplicate payments are largely not the result of fraud, but rather of a provider's submitting a second claim (not identified as a duplicate) when the first claim has not been paid in a reasonable period of time. It may be of value to states without duplicate claims checking ability to review the paid claims data base if the recovery potential is as great as that suggested by HEW auditors in Maryland. Also, this illustrates the fact that claims processing per se is not a preventive activity if claims are not paid expeditiously and if the system does not have appropriate claims edit checks.

Thirdly, the current claims processing system has the capability to generate some outcome reports such as provider profiles. This capability will be discussed in the next section on detection.

C. Detection

There are four primary sources through which cases are detected:

- Limited output reports from claims processing data;
- Agency employees, particularly claims processing clerks, who notice and report aberrations in claims;
- Limited verification of services with recipients; and
- Ongoing utilization review activities.

With respect to the first source, Maryland officials recognize a critical issue -- how to effectively use the machine generated reports. Staff report that their existing system has the capability to generate provider and patient profiles; that much has been said about the value of "profiles;" but that very little of a concrete and useful nature has been transmitted as to the "how" of using profiles. Maryland essentially has resorted to the basic "how" of high volume providers, and high ratios of dollars claimed per recipient.

Like other states with relatively unsophisticated capabilities, Maryland gives a great deal of credit to alert claims processing clerks who notice patterns or aberrations in claims and report their suspicions to investigations authorities. This is obviously a basically unsatisfactory non-system since it relies on the alertness of clerks whose primary function is not detection but processing. The clerks handle such a volume of claims that the likelihood of noticing a pattern or even an individual questionable claim is small. It should be noted that Maryland is not unique in mentioning this as a detection source and is not relatively more backward in this regard than many other states.

Maryland does not have Explanation of Medicaid Benefits (EOMB) capability, but does conduct verification of services with recipients on a limited basis. This is done in two ways: (1) occasional random samples of claims are selected for verification; and (2) once a provider is under suspicion from some other source a limited verification with recipients for whom he has submitted claims is conducted. In the former case, verification

is conducted through "validation studies" in which a small sample of recipients is sent letters asking questions about services for which claims were paid, and the satisfaction of the recipients with the services. These validation studies are conducted by the Division of Health Services Review to gain general feedback on the program and specific information on providers.

The second type of verification, provider-specific verification, is seen by state officials as having a very high "pay-off" rate. Such verifications, particularly in provider categories where verification is easy and conclusive such as dental services, can rapidly determine whether a reason for proceding with a case does or does not exist and can provide the initial evidence against a provider.

The final primary source of detection is "spin-off" from routine surveillance and utilization review. However, the lack of the MMIS S/UR subsystem or other readily usable machine generated reports has also hampered the S/UR activities conducted by the Division of Health Services Review. This Division is only two years old and has suffered staffing, learning and growing difficulties. It describes itself as using a "brush-fire" rather than a systematic approach to review. The Division's five staff members in this area are responsible for S/UR functions involving 26 categories of providers and approximately 8,000 individual providers. Each staff member is assigned several provider categories, which may or may not be similar or logically grouped together. In general, staff do not have extensive backgrounds in the health care field. A few procedures which are used include:

- Physician claims with more than five visits per recipient per month are pulled prior to processing and sent to the Division for review.
- A small sample of inpatient claims (7 percent) are selected and checked against length of stay norms each month. Claims with LOS' exceeding the norms are referred to the appropriate PSRO.
- The "validation" surveys of a sample of recipients to inquire by letter whether the services claimed were received, did the recipient pay the physician for the services, and was the recipient satisfied (as described above).

- Spot checks for pre-authorization on submitted claims.
- Review of county health department's monthly ledgers, which are submitted to the state as records of authorizations for prescriptions in excess of $20.

Exceptions reports are available to this Division, but are "not exceptional enough" as described by staff because the number of exceptions is substantially greater than the number the staff could realistically be expected to review. The Division anticipates that the MMIS will largely resolve this problem.

The outcomes of the activities of the Division of Health Services Review are discussed in a subsequent section of this report.

To summarize, the state, lacking the MMIS, has no satisfactory detection mechanism or system.

D. Investigations

Investigations are primarily the responsibility of the Division of Field Investigations. The Division of Health Services Review also conducts very limited "investigations" in conjunction with its S/UR responsibilities. However, these activities are primarily desk audits of claims and records and informal discussions with providers. Staffing and other limitations constrain any significant efforts by the Health Services Review Division.

The Division of Field Investigations has seven investigators; this is less than one investigator for each thousand providers. The Director estimates that particularly due to the implementation of the MMIS, the Division needs minimally eight to ten more investigators and two additional supervisors. As noted previously, the starting salaries are considered low and no particular investigative or educational background is required. The Director expects to have to train any new employees extensively.

The optimal level of cases is considered to be 25 cases per investigator at any given time. This level of cases allows investigators to efficiently schedule interviews, travel, etc. In August of 1976, the Division had a 1200 case backlog. Since the number of investigators is so small, they are all personally supervised by the Director.

Like other states, Maryland examines each case for its "prosecution potential," and actively pursues the "actionable fraud" cases. Exhibit

II-1 presents a short summary on each of five recent cases involving dentists. As can be noted from Case E, 74 counts were suggested by the investigation unit to the prosecuting attorney. This is in keeping with the state's philosophy of seeking court cases and maximum penalities. The outcomes of these cases will be discussed in the next section of this report. It should be noted that state law prohibits administrative agencies from closing cases involving criminal allegations and decisions in all such cases are made by the appropriate prosecuting attorney, not the Division of Field Investigations.

Investigations are conducted in a relatively standard manner and involve desk audits, visits to providers' offices, and interviews with recipients. As can be seen from Exhibit II-1, this unit uses a rule of thumb of 40-50 recipients interviewed to substantiate the allegations. Since the unit is primarily interested in prosecutions rather than recoveries, it builds cases on the number of recipients, claims, or whatever other criterion is appropriate to support the charges in court. It does not undertake an exhaustive analysis of all claims submitted to document total overpayments. This philosophical orientation significantly affects the amount of investigative time involved in each case.

The key characteristic of the Division of Field Investigations as an investigative agency is its emphasis on documenting cases and the method of presentation. The Director comments that many investigative agencies are interested in investigating, not in presenting cases for successful prosecution. He emphasizes that the quality of the method of presentation is the key to successful prosecutions. This is reflected in all aspects of the unit's work. For example, investigators are trained to record what the person says, not what the investigator thinks he said. Furthermore, each interview report becomes part of the case record not only to alert the prosecutor to what the witness can be expected to say on the stand, but also to refresh the witness's memory prior to giving testimony in court.

The Director reviews potentially prosecutable cases with the appropriate prosecutor at various stages of the investigation to ensure that final case reports meet the prosecutor's needs and that cases in which the prosecution has little interest are dropped before effort is spent preparing

ANALYSIS OF FIVE PROVIDER FRAUD CASES
DIVISION OF FIELD INVESTIGATION
MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION

A. Dentist

Thirty recipients - Charges $8,528 - Services rendered $1,483 - Overcharge $7,045 - % of overcharge 82.16%
Estimated projected overcharge 2 years - $12,790
Plea - Nolo Contendere - Repaid $7,045 - Fined $10,000 and costs
Dental Board suspended Dentist for 1 month

B. Dentist

59 recipients - Charges $20,462 - Services rendered $7,036 - Overcharge $13,426 - % of overcharge 65.5%
Estimated projected overcharge 3 years - $65,000
Plea guilty to 3 counts - Sentenced to 3 years - After 4 months balance of sentence suspended, placed on probation and ordered to repay DHMH $12,069

C. Dentist

51 recipients - Charges $30,000 - Services rendered $6,265 - Overcharge $24,050 - % of overcharge 79%
Plea guilty - 3 years probation - Repaid $24,050
Estimated projected overcharge 3 year $96,000
Dental Board suspended Dentist for 2 months

D. Dentist (Number of Dentists)

Payment of $4,602 for nursing home visits
Estimated $4,397 overcharge including 26 deceased patients
One dentist plea Nolo Contendere - Probation before judgement - Repaid $3,327 3 other dentists repaid $1,185 - but were not charged

E. Dentist

60 recipients - Charges $15,832 - Services rendered $3,880 - Overcharge $11,914 - % of overcharge 75.4%
Estimated projected overcharge 3 years $147,000
Charged on 74 counts - Plea not guilty - Jury Trial found Dentist guilty of 12 counts (State Attorney selected 12 counts for Trial)
Sentencing set for - September 15, 1976

Exhibit II-1. Summaries of Sample Dentist Cases

complete reports. Typically, a final case report going to the prosecutor contains approximately 1500 pages, including copies of records. The case involving a Prince Georges County dentist who received a sentence of four years in prison was several volumes long.

It should be noted that reports of this length are based on full, detailed investigations. In another state, the attorney general commented that the health department brought charges against a nursing home operator for feeding residents home canned foods, which is illegal under health codes. However, when the case was presented, the investigator had documented that the foods were in the basement of the home, but had not shown that any of the residents had been served or actually ate the foods. Thus, the case was unsuccessful, lacking this essential link in the chain of evidence. Such a result in unlikely in Maryland.

The reader is again referred to the draft investigator's manual included as Appendix A. It provides the investigator with the relevant statutes, statement of investigator's responsibilities, investigation procedures, and report outlines -- including sample report references. It also contains courtroom procedures and the Division's responsibilities for supporting a prosecution. The manual also includes relevant personnel policies and procedures.

E. Outcomes

1. Administrative Actions

Maryland does not currently use suspension or termination, but new program regulations being drafted include suspension. It is the opinion of staff that legislative amendment is required to implement these procedures. Therefore, there are only three routes currently available to staff for both program abuse and fraud:

- Informal conferences with providers to gain voluntary agreement to stop an aberrant practice and/or voluntary restitution;
- Referral to peer review groups; and
- Criminal prosecution.

The department does have an appeals mechanism available to providers, but the only situation in which a provider needs to appeal is a denial of a pre-authorization. Each Secretariat in Maryland has a hearings group which acts under the state's Administrative Procedures Act.

It is important to note that in two cases where a dentist pleaded either nolo contendre or guilty to criminal charges, the state Dental Board imposed only minimal license suspensions of one and two months, respectively.

Staff report that their impression is that there is more poor quality practice than program abuse or fraud and they have many questions about the authority of the state to tell providers what to do. Lacking sophisticated output reports from claims processing, it is extremely difficult to assess the extent of the fraud and abuse problem. These problems are further commented on in Section V.C. of this report.

2. Prosecution

As discussed earlier, the goal of state efforts is prosecution. Exhibit II-1 presented case summaries for five dental cases. The five cases resulted in four nolo contendre or guilty pleas so that the cases never came to trial. In each of these cases the provider was ordered to pay restitution. In two of the cases, relatively severe penalties were imposed -- a $10,000 fine in one case and a three-year sentence (subsequently reduced) in another.

In the fifth case (E), the newspaper article presented in Exhibit II-2 updates the record. In this case the dentist was sentenced to four years in prison. It should be noted that in four of the five cases there was no trial because the provider entered a guilty or nolo contendre plea in the face of charges. Trials, like other extreme measures, seem to be more useful for their availability than for their actual use.

The Division of Field Investigations prefers that charges are brought under the "obtaining money under false pretenses" provisions of the state general fraud statutes. This statute is presented in Appendix A. Although a misdemeanor under Maryland statutes, the possible penalties include imprisonment of not less than two and up to ten years. Each incident or act (i.e., claim for purposes of Medicaid provider fraud) carries this two- to ten-year penalty. Therefore, one case could involve multiple claims with each fraudulent claim warranting a two- to ten-year sentence.

Based on the previous discussion concerning case presentation and the prosecution orientation of the state, it is of value to note that none of these cases seems to involve really large amounts of money, using

Dentist Gets 4 Years in Medicaid Fraud

By Vernon C. Thompson
Washington Post Staff Writer

A Glenarden dentist was sentenced to four years in the Maryland penitentiary yesterday for defrauding the state's Medicaid program for the poor of over $2,400.

It is the harshest sentence given to a member of the medical profession in Maryland for Medicaid fraud thus far, state officials said yesterday, and one of the stiffest handed down anywhere in the country in connection with the growing number of convictions of doctors and dentists for Medicaid fraud.

Dr. Earlier Lee Trice, 42, who was found guilty on 12 counts of obtaining money under false pretenses under the Medicaid program, has made no decision yet whether to appeal the sentence, according to his defense attorney.

Assistant State's Attorney Howard M. Shemler was elated yesterday at the severity of the sentence. "Those dentists who would try the same crime will think twice," he said.

Trice faced a maxmium sentence of 10 years on each count.

According to the charges, Trice had billed the Maryland State Department of Health and Hygiene, which handles the Medicaid program for the state, for work he never performed on Medicaid patients.

The Medicaid program, funded by both the state and U.S. government, provides assistance to persons who cannot ordinarily afford medical payments. Payments are made directly to the physicians, who submit bills to the state for the work they have performed.

Investigators found that Trice was overcharging patients at a rate of 75 per cent, according to testimony. They then asked state dentists to examine 60 of Trice's patients.

Trice charged the 60 patients $16,000, but state dentists found only $4,000 of the work done, testimony showed. Trice had received more than $140,000 during the three-year period, Shemler said.

Testimony during the trial showed that in one case Trice claimed in a request for payment from the state that he extracted 38 teeth from the jaw of one patient when in fact, the jury was told by an expert witness, the human jaw rarely if ever contains more than 32 teeth.

In another instance, records were introduced that showed Trice claimed to have filled 13 teeth in the mouth of a patient from whom he had earlier claimed to have extracted 35 teeth.

Trice initially was indicted on 74 counts of seeking the money under false pretenses. The decision to prosecute him for 12 counts was made because it would have "taken a week and the (judge) was not going to sentence him to 740 years." according to Shemler.

A state report released recently had indicated that recipients of welfare and Medicaid help who subsequently were convicted of fraud were receiving harsher sentences than were dentists who were convicted of fraud in seeking payment for work not done.

Washington Post,
September 16, 1976,
page D6

Exhibit II-2. Newspaper Report of Dental Case "E"

the standards of some other states. In the last case the state had only documented $11,914 in overpayments and the dentist had only billed the program for $190,000 over three years. These are small sums of money for such a stiff sentence when compared to other states. However, since Maryland does not calculate all amounts which might be owed the state, actual amounts potentially represented by these cases could be higher.

At this time it is too early to tell whether the Prince Georges County sentence will stand or what the impact on the provider community will be. State officials do feel it is a major breakthrough with significant deterrent effects.

It should be noted that in Maryland the problems of an imbalance between sentences for providers (professional white collar crime) and recipients is more visible than in most states, and state officials have been very concerned. Until September 1976, jail sentences for recipients were not unusual and sentences in general were stiffer than those imposed on providers even though provider cases usually involved larger amounts of money. Therefore, state officials were pleased to see a sentence more commensurate with the crime handed down in the Prince Georges County dentist's case.

The Division of Field Investigations prefers to prosecute under state statutes and normally refers cases to local state's attorneys. This allows persons to be tried in their local community and prevents the longer delays encountered with prosecutions at the Federal level. This is not a comment on the interest or competence of the U.S. Attorney, but rather on the U.S. Attorney's schedules and other priorities. The Division does work with Federal authorities where mail fraud, income tax fraud or other issues of greater interest to Federal authorities are involved.

Although the general preference is to work with state's attorneys, the Division is currently discussing with the U.S. Attorney the possibility of bringing Federal charges to test the penalty provisions of Section 242 of P.L. 92-603, the Social Security Amendments of 1972. This section basically makes various fraud schemes a Federal offense with penalties of a $10,000 fine and/or up to one year in prison.

The state tends to prosecute the cases which are easiest to investigate and are likely to result in guilty pleas or convictions. All of the cases cited above involve dentists. The state readily admits that it is

much easier to gather conclusive evidence against dentists and that the machinery for doing so against other types of providers, particularly physicians, is not nearly so well developed.

The state's prosecution record should not be read as a positive reflection on the prevention or detection aspects of the system. In the Prince Georges County case, the claims processing system paid for fillings to teeth for which it had previously paid for extractions and paid for 38 extractions in one mouth in another instance. These are the grossest types of aberrant practices and therefore easiest to detect when not prevented in the first place.

3. Restitution

As can be seen from Exhibit II-1, in four of the five cases repayment of funds was part of the sentence. The only other mechanisms for recovery in Maryland are voluntary restitution and recoveries through routine institutional audits and rate adjustments. As noted previously in this regard the state has collected $170,000 of overpayments due to the payment of duplicate claims (see Section II.B.Prevention).

As has also been pointed out, restitution is not a primary goal in the state, so the amounts involved in court cases are relatively small, since the quality of the evidence, not the size of the amounts, will dictate the outcome. In only one case was the provider penalized financially in excess of the overpayment amount. The total amount of restitution from these five cases was $47,676.

III. RECIPIENT FRAUD AND ABUSE CONTROL PROGRAM

In discussing Medicaid recipient fraud and abuse control in Maryland, it is necessary to distinguish between systems and procedures. There are no systems in the sense that there is no system of prevention or detection and no one person assigned to Medicaid recipient related functions. However, there are procedures employed with respect to particular sets of circumstances. Since the Director of the Division of Field Investigations/ Medical Care Programs Compliance Administration/Department of Health and Mental Hygiene is also the state coordinator for recipient fraud investigations with respect to the public assistance programs of the Department of Human Resources, the Medicaid and public assistance programs overlap at

this one point. The result of this is that when public assistance recipients are under investigation for ineligibility, the investigator may ask the Director of Field Investigations for information on medical assistance benefits paid on the recipient's behalf during the period under investigation. The Director gets this information from claims processing, usually within 24 hours, and provides it to the investigator who adds it to the case. If recoupment of funds paid out by Medicaid is successful, a check is sent to the Director for return of the funds to the Medicaid program.

The second procedure used relates to the issuance of medical assistance cards. Maryland uses plastic credit card type medical assistance cards which are issued at three month intervals. Each card has an 11 digit identification number, the period for which it is valid, and the recipient's name in addition to the "State of Maryland Medical Assistance Program" identification. If there is some reason to suspect recipient abuse, the Director specifies that the next card issued be mailed to him rather than to the recipient. The address of the case actually becomes "in care of" the Director, Division of Field Investigations. When a card is received in the Director's office, a routine letter notifying the recipient that the card is being held and specifying an appointment time is sent by certified mail. Cards are held only for adults; children's cards are not held even if the adult's in the case is. If the recipient does not contact the office, the case worker is notified so the case can be reviewed or closed as appropriate. If the recipient does contact the office, the Director discusses with the recipient the issue in question. Based on this discussion, he determines whether or not a serious problem exists and whether further follow-up is appropriate.

There is no system for detecting abuse; such instances would generally include complaints, S/UR picking up unusual amounts of prescription narcotics, or the card being returned by the post office as undeliverable at the address given.

To summarize, two procedures exist for specific instances where "cases" come to the Director's attention. However, there is no system for detecting medical assistance recipient fraud and abuse. The existing claims processing system has some capability to generate patient profiles, but they have not been used effectively partly due to staffing constraints.

IV. AGENCY FRAUD AND ABUSE CONTROL

There is no program to systematically detect or investigate agency fraud and the state reports that there is no problem in this regard in the Medicaid program. The only example which could be cited was an instance where claims processing clerks were showing favoritism to some providers to expedite processing of their claims, but no fraud was found to exist.

V. PROGRAM ASSESSMENT

A. Introduction

The purpose of this study is to document exemplary or "best practices" currently being used by selected states in their fraud and abuse control efforts that may be useful to other states. To accomplish this purpose, certain states were selected for site visits. In these states it was necessary to review many aspects of the administration of the Medicaid program in order to understand the environment in which the fraud and abuse control efforts exist. This rather comprehensive review, however, was not in any way intended or structured to provide an evaluation of the state except in the limited "best practices" sense. Also, no state was expected to have a completely exemplary system across all fraud and abuse control functions -- prevention, detection, investigation, prosecutions, etc. Maryland was selected for its investigations unit and prosecutions resulting in significant penalties. Although this is not an evaluation, it is useful to record the state's comments on its program and our comments on the environment, especially to the extent that some activities may be of use in only that environment or could not be duplicated in a different environment.

B. State Self Assessment

Although the state was not asked for a comprehensive assessment of its program, a few comments made by state staff are presented in the following paragraphs. Generally these comments are explored further in the succeeding section on conclusions or in the best practices section of this report.

Claims Processing

As noted previously, state officials are well aware of the limitations of the current claims processing system and are working toward

installing the MMIS. For that reason -- claims processing is not an exemplary practice in Maryland -- it has not been addressed extensively in this report.

Pre-Authorization

Although the pre-authorization system is relatively new in Maryland (established in January 1976), state officials think it is an effective program. State staff are struggling with the S/UR functions particularly with regard to the "authority" of the state to impose standards on providers. Staff readily admit that, like other states, the program regulations are not as clear or up-to-date as is desirable.

Staffing Limitations

Maryland also has a problem similar to that of other states concerning budget and position limitations, particularly as noted in the investigative staff area. This has an impact not only in terms of the total amount of resources and staff applied to fraud and abuse control, but also in terms of the qualifications of staff. However, as discussed in the best practices section of this report, Maryland provides an example of effective activities within these constraints.

Types of Fraud

Maryland has not identified the elaborate fraud schemes detected in some other states. Officials note that the program requires a written order from a physician with each laboratory claim and pays for laboratory services on a fixed fee basis. They feel this accounts for the lack of a problem in laboratory services such as that experienced by Illinois which reimburses on a usual and customary basis. The pharmacy claim form also requires the physician's signature.

Penalties

Program officials have been very dissatisfied with the sentences as a result of guilty or nolo contendre pleas in the court cases of the past year, since they did not feel the punishments provided the deterrent effect the state sought in bringing the charges. They were also concerned over the lack of follow through by the state licensing authorities. As noted earlier, the dentists involved in these cases maximally had their licenses suspended for two months. This is of particular concern to officials since some substantial jail sentences (18-48 months) have been handed out in recipient fraud cases incolving similar or lesser amounts of money.

C. Conclusions

Maryland does not appear to have any unique characteristics that make the good practices used in this state non-exportable. Geographically and demographically it is like many other states in that there is a concentrated urban population (Baltimore-Washington metropolitan area) with a concentration of program recipients and providers and many rural counties. Although the state and program organizational structures vary significantly from many other states, the structure does not appear to be a determining factor in either procedures or outcomes.

Although casual observation might suggest that the fraud control efforts are personality dependent on the Director of Field Investigations, the procedures he employs and characteristics he exemplifies are sound and discussed further in the best practices section of this report. Program officials talk knowledgeably about fraud control and the importance of it within the context of a sound management control system.

Although the reader is again reminded that this is not an evaluation of Maryland, a few observations are relevant in that they support the best practices seen in other states.

First, the lack of any significant action by the dental board in cases of dentists convicted of fraud against the state is disappointing and similar to the experience of other states. The license suspensions of one to two months probably essentially constitute much needed vacations for providers who have fraudulently overbilled the state. It must be remembered that licensing and examining boards tend to be creatures of the providers they regulate, and we have seen no state Medicaid program that reports very high satisfaction with the follow-up actions of such authorities. Furthermore, both the program and the licensing authorities are necessarily concerned with not needlessly reducing the number of providers so as to endanger the population's access to available care. However, it seems that at a minimum the Medicaid program, like Medicare, must have discretionary authority to suspend or terminate providers who on the whole are a greater detriment than assistance to the program. The principle of conditions of particpation is well established and the Medicaid program in some states is needlessly dependent on the licensing authorities

who do not necessarily share similar objectives and are unlikely to meet the program's needs in this area.

Secondly, staff report that they feel there is more poor quality practice than program abuse and fraud. States with good MMIS systems rarely report this perception although they of course recognize the problem of quality of care in addition to abuse and fraud. Although most states lack the capability to precisely estimate the fraud and abuse, the MMIS reports do provide certain indicators in terms of numbers of exceptions for certain criteria and time frames.

Short of criminal prosecutions, staff reported having questions about the legitimate role of the program and the authority of the program to tell providers what to do. There also appears to be a correlation between these types of questions and a lack of administrative sanctions. Staff in strong, active states tend to see the authority of the program to legitimately protect its integrity as almost limitless. Lack of a strong and sufficient base of regulations and administrative penalties puts staff in no position to stand up to providers who question the program's role in regulating their practices.

To summarize, a strong fraud and abuse control effort can only be founded on a base of sufficient authority and regulations. Regulations in terms of provider handbooks and provider agreements must specify what is acceptable to the program and what is not and the penalties for non-compliance. For example, one state identified extensive prescription splitting, but also discerned that the pharmacy handbook did not address this issue, so no action could be taken until new regulations were promulgated since splitting was not at the time a violation of regulations.

Major attention in some states should be given to review and re-writing regulations, equal to the attention given the more obvious functions of detection and investigation. States without sufficient regulations will never have effective fraud and abuse control programs. To the extent that Federal regulations can support state efforts or short-cut time consuming state regulation promulgation barriers, this may be a desirable option.

VI. BEST PRACTICES

A. Introduction

"Best practices" for purposes of these reports have been defined to include both specific procedures and concepts which appear to be transferable to and replicatable in other jurisdictions. Necessarily, the assessments of what constitute best practices are based to a great extent on each state's own assessments of the strengths of its program and on the analyst's knowledge of the state of the art nationwide and therefore what represents an advanced or exemplary practice. Necessarily also, best practices describe characteristics such as organizational structure or staff qualifications which appear to facilitate quality performance.

Although the study has used a generic definition of fraud and abuse control to include claims processing, provider education, surveillance and utilization review, etc. in addition to fraud investigations per se, the best practices in Maryland all directly relate to the latter area. From these state reports a final analytic report which describes the best practices observed in all states in all of the functional areas -- prevention, detection, investigation and outcome -- will be prepared. It is essential that fraud and abuse control be understood as a continuum of these functions and as an integral part of overall Medicaid program management control.

B. Prosecution as an Outcome

As noted in other case studies, states have adopted various philosophical approaches to fraud and abuse control and various objectives which have dictated the structure and procedures utilized. Maryland represents a state which has selected prosecution as its objective. While this may have in part been dictated by staff size, it is useful to explore the pros and cons of prosecution as the desired outcome. The selection of prosecution also describes the circumstances which make the subsequent "best practices" exemplary and useful.

First, Maryland officials agree strongly with the opinion expressed by other states that a few good prosecutions are the best deterrent available. It should also be noted that "prosecution" in the lay use of the word is a misnomer. In Maryland, in fact, very few cases actually came to trial.

The investigators build cases suitable for prosecution. Once a provider is indicted, plea bargaining and guilty or nolo contendre pleas are more likely than actual trials if the case is well developed and therefore likely to result in a successful prosecution. Therefore, the Medicaid program really interfaces with the criminal justice system in terms of getting a case indicted and in the plea bargaining, sentencing processes. The cost to the criminal justice system is rarely the cost of a trial. Although this is not so clearly the case in some other states, it appears that a well developed prosecution potential, like other mechanisms such as suspension, is more valuable for its demonstrated existence in a few cases rather than in its actual use in many cases. A few cases resulting in notable sentences are, according to many states, an effective deterrent to other providers considering attempting to defraud the program and an incentive to the provider once caught to cooperate and pay restitution or negotiate some other suitable resolution. Unsuccessful cases (summary judgments of acquittal, finding of not guilty, light sentence) are thought to work in the reverse and provide positive incentives toward fraudulent activities since the penalties are demonstrated to be negligible if caught. Therefore, it is critical that if a state seeks prosecution as an outcome that the case is strong enough and handled well enough so as to result in "success" in terms of the negative incentives and deterrrent effect the state seeks to achieve. It is not enough merely to refer cases to prosecution unless the "hassle value" for providers is the objective of the program or unless the mere visibility of program efforts to control fraud is considered to outweigh the possible fraud incentives of low cases referred/cases successfully prosecuted ratios.

All states agree that the deterrent value of a prosecution lessens with the passage of time, so to be continually useful as a deterrent successful prosecutions must regularly occur as long as fraud exists.

Maryland is a state where prosecution is a "pure" outcome; that is, its deterrent value alone is the objective. However, the value of prosecutions as an incentive for providers to cooperate and negotiate resolutions should also be capitalized on to maximize on the investment in the investigation. For each provider prosecuted, there are probably at least

several more for whom prosecution is really not suitable or likely, but who are more willing to settle at a lower level of the process due to the fear of prosecution whether that fear is valid or not. To capitalize on this, the state must have a branching process with resolution possible at various levels short of prosecution. In states without this branching process, once the fraud investigator has determined that a case is not suitable for prosecution, the case is likely to be dropped and the provider is "off the hook" altogether. Since cases can be dropped for purposes of fraud prosecutions for reasons not necessarily indicating that the provider is innocent of any program abuse or fraud, it is essential that mechanisms exist for dealing with providers in other ways. Cases can be dropped because a prosecuting attorney is too busy, because the case does not have jury appeal, because fraudulent intent cannot be proved although obvious abuses such as unnecessary referrals and tests, etc. have led to overpayment to the provider. Not having these other mechanisms (suspensions, restitution collection procedures, probation) is like saying that there should be no attempt to collect for overpayments paid to the provider because he submitted duplicate claims without fraudulent intent. Furthermore, since fraud prosecutions typically take a long time in the interim between the development of enough evidence and resolution of the case, the program could pay many more of the provider's claims than those in the original investigation. Therefore, to protect program funds, the program needs a mechanism to screen all incoming claims or suspend payment to the provider. This typically is not an investigator's responsibility for he is only responsible for building a prosecutable case, not necessarily performing other program integrity functions.

Therefore, while prosecution is a legitimate and valuable outcome, the value of these extremely costly investigations can be maximized within the context of a larger fraud and abuse control effort through availability of procedures with other outcomes.

If a state does not have large resources to invest in fraud and abuse control, the Maryland approach of minimal staff seeking the publicity/deterrent value of a few successful prosecutions is probably useful. This is the largest "bang for the buck" theory. It is unlikely that other objectives

such as primarily seeking restitution, would be any more effective, particularly without the strong support of the necessary elements of prevention and detection. In this case prosecution substitutes for other prevention activities and the most obvious cases are creamed off for prosecution, saving detection time. Some states spend so much time using exception reports and "detecting" cases that detection is the implicit outcome since there are relatively little resources left to investigate and seek other outcomes. Maryland essentially avoids expending much of its limited resources on detection and puts all of its resources into investigations of obviously prosecutable cases, the results of which have deterrent value and give the state program integrity efforts high visibility.

C. Personnel

The draft of the Maryland investigator's manual presented as Appendix A is a best practice in and of itself as one of the clearest and most useful documents available on the subject. Even if the staff were comprised of trained investigators, the necessity of such a manual tailored to this particular set of circumstances is essential. The risk of investigator's exceeding their authority is implicit in any investigation agency and this document provides clear instructions on the responsibilities of investigators and procedures to be followed.

The second best practice in this regard, observed in Maryland and other states, is the qualifications of the investigation agency head. In Maryland the Director of the Division of Field Investigations is an ex-FBI agent with experience not only in investigative technique, but also in management and supervision. It appears that management of fraud and abuse control efforts, particularly investigations, requires an individual with previous management and supervisory experience who knows police procedures and their dangers, who can evaluate staff performance, and who can perform the functions of planning, budgeting, negotiating with state agencies and program representatives and who can perform all of the other functions required of a unit director. There is a clear distinction which should be made between an ex-investigator and an ex-investigator/manager when selecting staff for supervisory jobs. Individuals with such experience appear to have better skills for making the transition from a policy agency to a human services agency and for adapting their techniques accordingly.

D. Case Documentation

A key feature of the Maryland investigation procedure is the strong emphasis on the method of case documentation and presentation. The investigator's draft manual presented as Appendix A contains a section on report preparation. The Director of Field Investigations makes a valid point that many individuals like to investigate and can do good investigations, but that each investigation is only as good as what results from it. The essential link between a good investigation and the outcome of it is the documentation and presentation of the case to the prosecutor who is expected to act on the case.

Since Maryland is a relatively rare example of a state which has successfully prosecuted providers and achieved jail sentences in two cases, the relationship between the Medicaid program and the prosecutors was explored in some detail. Although there is a prevailing attitude in some quarters that the lack of prosecutions is caused by a lack of interest and cooperation on the part of prosecutors, this has not been generally found to be the case. Both prosecutors and investigators have suggested that prosecutors are generally willing to take a provider prosecution if it involves a "good" case. Both prosecutors and investigators tend to agree that this is a hackneyed and outdated rationale for lack of prosecutions. Both also tend to agree that a high number of prosecutions in any jurisdiction is neither feasible nor desirable from both the prosecutor's and program's points of view, but that a few good cases are feasible and desirable from all standpoints. It is important to remember that the criminal prosecution route is appropriate for only the small number of cases actually involving fraud and that the prosecutor cannot be expected to resolve all of the program's problems since many "cases" involve program abuse, or unprosecutable fraud.

A "good" case involves several elements:

- Sound charges, jury appeal and the other characteristics which make a case worthy of time on the public docket.
- An uncontaminated chain of evidence which supports the charges in all respects.

- Documentation and presentation of the case so that the prosecutor can readily work with it and asses its priority within the context of his other case priorities.

This last element appears to be where Maryland exceeds other states. There is great emphasis in this state on presenting the prosecutor with a complete and comprehensive case report essentially ready for trial. While some argue that the program is doing the prosecutor's work for him, it should be remembered that this is the basic pattern of investigation/prosecution interface. Police agencies do not refer murder cases for prosecution without a clear, well presented case of witnesses, evidence, etc. Since the investigator knows the case best, it stands to reason that he/she is also best able to present it. Most investigators with whom we have discussed this issue readily agree although we saw it most dramatically illustrated in Maryland. Investigators feel in general that almost any case has to be "sold" to a prosecutor and the best way to do that is through a good case report. It is hard for a prosecutor to justify turning down a case that contains all of the elements he requires with full documentation.

The case report in Maryland contains the following elements:

- Contents section with overview of the case and outline of the report.
- Background and Operation of Medicaid -- this section gives the prosecutor the background information on the program which he needs.
- Synopsis -- summarizes the case including allegations, evidence, and amount of overpayment involved.
- Predication -- why the investigation was begun.
- Details of the investigation -- this is the heart of the report with a description of the investigation and the evidence presented.
- Appendix -- provides the back-up information and evidence such as copies of claims, witness statements, etc.

Of course, once a case begins to suggest that prosecution is desirable, the Division begins to work with the prosecutor involved so that the final report meets his needs and he is aware that an important referral is coming.

Massachusetts with its high ratio of referrals:prosecutions also works from the premise that the case must be "sold" and that good documentation is the necessary element of a sale. The Maryland experience confirms that this is indeed a "best practice" which should be followed by other states.

Appendix A

STATE OF MARYLAND INVESTIGATIVE MANUAL

INVESTIGATIVE MANUAL

Division of Field Investigation
Medical Assistance Compliance Administration
Department of Health and Mental Hygiene

June, 1975

This temporary manual is being put into operation at this time to lay a basis for a complete manual in the future.

Any recommendation for additions and/or deletions to this manual should be submitted in writing to the Chief of Field Investigation.

Procedures set forth in this manual are not totally conclusive and each investigator must use his own initiative and expertise to accomplish our overall goals, staying within guidelines established for this Division.

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CHAPTER I

AUTHORITY OF DIVISION OF FIELD INVESTIGATION

Chapter I

Authority of the Division of Field Investigation

On September 15, 1969, Attorney General Francis B. Burch addressed a letter to Dr. Neil Solomon, Secretary of Health and Mental Hygiene, a copy of which is attached.

As a result of the attached recommendation a "Fraud Squad" was organized within the Administrative office of the Medical Care Programs Administration of the Department of Health and Mental Hygiene, effective December 29, 1969.

This "Fraud Squad" was organized also in compliance with the "Code of Federal Regulations, Part 235 - Administration of Financial Assistance Programs Section 110 - Fraud".

This Code states: "State Plan requirements: A State plan under Title I, IV-A, X, XIV or XVI of the Social Security Act must provide:

"a. That the State Agency will establish and maintain:

"1 - Methods and Criteria for identifying situations in which a question of fraud in the program may exist, and

"2 - Procedures developed in cooperation with the State's legal authorities for referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced

"The definition of fraud for purposes of this section will be determined in accordance with State law.

"b. For methods of investigation of situations in which there is a question of fraud, that do not infringe on the legal rights of persons involved and are consistent with the principles recognized as affording due process of law.

"c. For the designation of official position(s) responsible for referral of situations involving suspected fraud to the proper authorities."

OFFICES OF
THE ATTORNEY-GENERAL
ONE CHARLES CENTER
BALTIMORE, MARYLAND 21201

Attorney General J. Shiffler
Ike Moss

September 15, 1969

Dr. Neil Solomon
Secretary of Health and Mental Hygiene
701 State Office Building
301 West Preston Street
Baltimore, Maryland 21201

Dear Dr. Solomon:

As you are aware, many investigations involving alleged medicaid frauds by doctors, dentists and pharmacists have been directed by this office during the past year and a half. These investigations have resulted in the prosecution of seven doctors and dentists and additional prosecutions of eleven doctors, dentists and pharmacists are pending. To date, fines and restitutions totaling $75,000.00 have been assessed and recovered by the State. The actual investigation of these matters has been conducted by detectives of the Baltimore City Police Department and the Maryland State Police, however the overall direction and coordination of investigation and prosecution efforts have been handled by an assistant assigned to my staff.

It is our considered opinion that there is a real need for a full-time investigator experienced in fraud matters to be retained and appointed to the Department of Health of the State of Maryland to handle these matters. An individual, believed by me to be eminently qualified, is currently available for this assignment.

In view of the numerous medicaid frauds which have developed in Maryland and throughout the Country, I feel strongly that the public interest demands a permanent and full-time investigator be assigned to the Health Department to handle these investigations.

At a meeting with the Governor on September 11, I advised him of my feeling on this matter, and he has authorized me to advise you that he agrees with my recommendation.

Sincerely,

Francis B. Burch
Attorney General

FBB:HEL:F

CC: Honorable Marvin Mandel
Dr. William J. Peeples

CHAPTER II

OPERATING POLICY OF THE DIVISION OF FIELD INVESTIGATION

Chapter II

Operating Policy of the Division of Field Investigation (DFI)

Investigators are to remember that the conduct of all employees of this Division and their work reflects not only on their professionalism but also on the office of this Division.

The Division of Field Investigation (DFI) is not responsible nor empowered to act as a law enforcement agent of the State. We are an investigative body with the primary mission of ascertaining facts and circumstances surrounding alleged fraud in the payments and receipt of monies and or benefits through State administered Assistance programs.

It should be noted at this point that this Division and its staff are not in the role of prosecution. Investigators should work closely with State's Attorneys and assist them in collection of evidence, appearing as witness upon request, and by discussion of their investigations. Investigators should be prepared to complete, as soon as possible, any additional investigation requested by a State's Attorney, within our investigative guidelines.

In view of our responsibilities, we will conduct our investigations in a "low-key" manner. Force, threats, promises will not be tolerated. A courteous, polite and cooperative spirit is to be used in our approach to all parties in our investigations.

Investigators of this Division are not issued weapons of any type nor are they authorized to carry on their person any type weapon while performing their duties. Should a situation arise where violence might be encountered or is imminent, the investigator should withdraw immediately. Good rapport with local and State law enforcement agencies is encouraged so their assistance can be sought should this be necessary.

We should be alert to report failure of recipients to receive their just benefits as we are to report fraudulent intent and acts. Our goal is to raise the level of benefits available to legitimate recipients by reducing the number of recipients receiving aid illegally. Our motto is, "Eliminate the greedy - Help the needy".

Members of this Division, will not at any time, make public releases as to our opinions, activity, or results of our investigations. Any inquiries regarding these matters should be directed to the Chief of Field Investigation.

Investigators of this Division must live up to the professional standards established and are to become completely familiar with the "Expectations of the Investigator" as devised by the Chief of the Division and the Chief Investigator.

(See "Expectations of the Investigator" attached)

DIVISION OF FIELD INVESTIGATION
MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION

Expectations of the Investigator

You will thoroughly familiarize yourself with the administrative procedures of the Office of the Division of Field Investigation, and will insure that you are operating within these provisions at all times.

You are expected to develop a good working knowledge of the programs within which we are currently operating and any additional programs that might be added as they occur. This knowledge is to be demonstrated in conducting and presenting your assigned investigations.

One of the most important responsibilities will be the conducting of sensitive investigations requiring the utmost in the areas of professionalism, resourcefulness, initiative, tact, sound judgement, effective communication, and confidentiality.

You will be expected to meet the required level of productivity as required by Division standards, and will promptly report any operational problems that might affect this productivity. Meeting these standards is considered minimum requirement of performance. In this regard, you will be directly responsible, in all matters related to this Office, to the Chief of the Division.

You are expected to pay particular attention to the quality of your work. Your investigative reports will be complete, concise and factual. They will be a complete product when submitted for review to the Chief Investigator.

You will be responsible for all cases assigned to you by the Chief Investigator and through effective use of the case status checklist, be prepared to discuss the status of each case assigned when requested to do so by the Chief Investigator.

You are expected to conduct yourself at all times in such a manner as not to cause doubt upon the professionalism, thoroughness, or individual efforts associated with the Office of Field Investigation. You will not discuss race, religion, politics, or medical assistance policy during the course of interviews with prospective witnesses.

Other expectations of the Investigator are performance standards which are supplemental to the rating factors set forth by the State of Maryland. These performance standards will be considered the minimum performance standards for the position of Investigator.

Please discuss any of these standards and their application with the Chief Investigator at any time necessary.

CHAPTER III

STATE AND FEDERAL LAW

Chapter III

State Law

Laws covering Medical Assistance Fraud in the State of Maryland can be found in the 1974 Supplement of the Annotated Code of Maryland -

Article 27, Section 230 A - Obtaining Public Assistance by Fraud.

Article 88 A, Section 62 - Applications for Assistance to be written and signed; false or fraudulent statements punishable as perjury.

Attached are copies of Article 27 and Article 88 A.

In cases involving fraud on part of Providers of Medical Assistance refer to:

Article 27, Section 140 - Obtaining money, etc. under false pretenses with intent to defraud.

See attached copy of Article 27, Section 140.

Federal Law

Law concerning Medical Assistance fraud can be found in Article 42-1396h United States code (Section 1909 Public Law 92-603)

See Attached

FRAUD — WATCHES

§§ 224-228. Secondhand watches.

Repealed by Acts 1975, ch. 49, § 1, effective July 1, 1975.

Cross reference. — For present provisions as to secondhand watches, see CL, §§ 14-701 to 14-706.

FRAUD—WELFARE

§ 230A. Obtaining public assistance by fraud.

(a) Any person who fraudulently obtains; attempts to obtain, or aids another person in fraudulently obtaining or attempting to obtain money, property, food stamps, medical care or other assistance to which he is not entitled, under a social, health, or nutritional program based on need, financed in whole or in part by the State of Maryland, and administered by the State or its political subdivisions is guilty of a misdemeanor. For purposes of this section, fraud shall include:

(1) Wilfully making a false statement or representation; or

(2) Wilfully failing to disclose a material change in household or financial condition; or

(3) Impersonating another person.

(b) Upon conviction, after notice and the opportunity to be heard as to the amount of payment and how the payment is to be made, the person shall make full restitution of the money, property, food stamps, medical care or other assistance unlawfully received, or the value thereof, and shall be fined not more than $1,000 or imprisoned for not more than three years, or both fined and imprisoned.

(c) Any person receiving assistance at public expense shall read, or have read to them, a statement of what conduct constitutes fraud under this section and shall sign a statement acknowledging that he understands that the penalties for welfare fraud may be a fine of not more than $1,000 or imprisonment for not more than three years, or both fine and imprisonment. (1968, ch. 312, § 2; 1970, ch. 193; 1974, ch. 428, §§ 1, 2; 1975, ch. 328.)

Effect of amendments.

The 1974 amendment, effective July 1, 1974, rewrote the section.

The 1975 amendment, effective July 1, 1975, added subsection (c).

Amount of money is not an element.— The amount of money involved is no more an element of the offense than it is in a robbery. Gentry v. State, 12 Md. App. 44, 276 A.2d 673 (1971).

State need not prove exact amount alleged.—It was sufficient for the State to establish that the accused received some public assistance to which he was not entitled; whether in an amount greater or smaller than the amount charged was not material. Gentry v. State, 12 Md. App. 44, 276 A.2d 673 (1971).

The verdict of guilty was proper even though the State had not proved the exact amount alleged. Gentry v. State, 12 Md. App. 44, 276 A.2d 673 (1971).

That the amount proved is less than the amount alleged does not vitiate the conviction. Gentry v. State, 12 Md. App. 44, 276 A.2d 673 (1971).

Accused improperly convicted twice. — Where the accused unlawfully obtained public assistance to which he was not entitled by failure to disclose a change in his household, the marriage of his daughter, but the money he received by

PROHIBITED ACTS

§ 62. Applications for assistance to be written and signed; false or fraudulent statements punishable as perjury.

Every application for money, property, food stamps, medical care or other assistance, under a social, health, or nutritional program based on need, financed in whole or in part by the State of Maryland, and administered by the Department of Employment and Social Services, or the Department of Health and Mental Hygiene, or by the local department of social services, whether under this or any other article in this Code, shall be in writing and signed by the applicant. Any person who in making and signing such an application makes a false or fraudulent statement with intent to obtain any such money, property, food stamps, medical care or other assistance is guilty of perjury and upon conviction therefor is subject to the penalties provided by law for perjury. (1964, ch. 47; 1968, ch. 702, § 1; 1974, ch. 428, § 3.)

Effect of amendment.

The 1974 amendment, effective July 1, 1974, rewrote the first sentence and added "such money, property, food stamps, medical care or other" in the second sentence.

§ 140. Obtaining money, etc., under false pretenses with intent to defraud.

Any person who shall by any false pretense obtain from any other person any chattel, money or valuable security, with intent to defraud any person of the same, shall be guilty of a misdemeanor, and being convicted thereof shall be liable, at the discretion of the court, to be punished by fine and imprisonment, or by confinement in the penitentiary for not less than two years nor more than ten years, as the court shall award; provided always, that if upon the trial of any person charged with such misdemeanor it shall be proved that he obtained the property in question in any such manner as to amount in law to larceny or robbery, he shall not by reason thereof be entitled to be acquitted of such misdemeanor; and no person tried upon such misdemeanor shall be afterwards liable for larceny or robbery upon the same facts; and provided also, that a mere promise for future payment, though not intended to be performed, shall not be sufficient to authorize a conviction under this section. (An. Code, 1951, § 165; 1939, § 150; 1924, § 139; 1912, § 122; 1904, § 112; 1888, § 82; 1835, ch. 319, §§ 1, 2; 1953, ch. 197; 1961, ch. 616, § 9; 1961, Sp. Sess., ch. 14, § 2; 1963, ch. 184; 1965, chs. 235, 838; 1967, ch. 205; 1968, ch. 306; 1970, ch. 350; 1972, ch. 181, § 28; ch. 397.)

Effect of amendments.

Chapter 181, Acts 1972, effective July 1, 1972, eliminated the former second sentence, giving to the people's court and trial magistrates in certain counties concurrent jurisdiction with the circuit court, and the former third sentence, giving jurisdiction to the Municipal Court of Baltimore City.

Chapter 397, Acts 1972, effective July 1, 1972, gave effect to ch. 181 and in addition eliminated "to be prosecuted" following "mere promise" in what is now the last proviso.

Elements.

The crime is committed when a person: (1) by making a false representation of a past or existing fact; (2) with intent to defraud; and (3) knowledge of its falsity; (4) obtains any chattel, money or valuable security from another; (5) who relies on the false representation; (6) to his detriment. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

A false pretense is committed when a chattel, money, or valuable security is obtained from another by making a false representation of a past or existing fact with intent to defraud and with knowledge of its falsity. Bosley v. State, 14 Md. App. 83, 286 A.2d 203 (1972).

The gravamen of this offense is the intent to cheat or defraud. Bosley v. State, 14 Md. App. 83, 286 A.2d 203 (1972).

The false pretense is the crux of the crime. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971); Bosley v. State, 14 Md. App. 83, 286 A.2d 203 (1972).

The false representation or pretense

may be made in any form or manner. It may be made by words, or conduct that has the effect of misrepresenting existing facts to the victim. The false representation may be made in writing, orally or by telephone. It is immaterial that the false representation was ambiguous, when the intent and reasonable effect of defendant's conduct was to mislead the victim. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

Knowledge of falsity.—The requirement of knowledge is not limited to knowledge in the true sense. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

If the representation is really untrue this part of the requirement is satisfied if it is made by one who knows it is untrue, or believes it is untrue, or is quite aware that he has not the slightest notion whether it is true or not. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

If the representation was untrue the accused would have "knowledge" if he actually knew it to be untrue or if he believed it to be untrue or if he was aware that he did not know whether it was true or not. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

Section requires proof of fraudulent acquisition of ownership, not mere possession. Carey v. State, 19 Md. App. 695, 313 A.2d 696 (1974).

Which necessitates showing of owner's, as well as accused's, intention. — The requirement of proof of the fraudulent acquisition of ownership necessitates a showing of the intention of the owner as well as the accused. Carey v. State, 19 Md. App. 695, 313 A.2d 696 (1974).

"False pretenses" and other crimes distinguished by reference to form of taking. —Within the frame of reference of the taking, it is larceny if the taking is trespassory. If the taking is not trespassory, it is false pretenses when title to the goods as well as possession is obtained by fraud; it is embezzlement if a servant or employee fraudulently converts to his own use goods of his master or employer which are in the possession of the servant or employee; it is larceny after trust if a person entrusted with the possession of goods for the purpose of applying them for the use and benefit of the owner or person who delivered them fraudulently converts them to his own use. Farlow v. State, 9 Md. App. 515, 265 A.2d 578 (1970).

The property need not be obtained by accused for himself, it being sufficient, if, as a result of his false representations, it is delivered either for the benefit of accused or for another's benefit. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

The property need not be delivered to accused himself; it is sufficient if it is obtained by another on his account. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

The defendant is responsible for his false pretense even though he did not personally gain any benefit from the goods which had been obtained thereby. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 cused, will not relieve him of criminal liability. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

There is no doctrine of lueri causa in the field of false pretenses. It is accordingly immaterial that the defendant did not gain or intend to gain any personal benefit (1971).

That the false pretense is made for the benefit of another, and not for the ac- or advantage from obtaining the property from the victim. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

It is sufficient that the thing has been confided to the offender, it being immaterial that he did not obtain it on his own account, nor for his own gain or benefit. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

It was not material that the money obtained from the victim was not shown to have been appropriated by the accused. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

Section 690 of this article does not change this section or article 57, § 11. — The legislature, when enacting § 690 of this article, made no change in this section (providing that persons convicted of false pretenses could be sentenced to the penitentiary), nor did it change article 57, § 11 (providing crimes punishable by confinement in the penitentiary were not covered by the one-year statute of limitations). Spillers v. State, 10 Md. App. 643, 272 A.2d 49 (1971).

All participants in the offense are chargeable as principals.—As false pretenses is a misdemeanor all those participating in the offense, whether as principal or perpetrator, accessory before the fact, or aider or abettor are chargeable as principals. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

In a misdemeanor a person may be chargeable as a principal if he performs some act or takes some part in the com-

mission of the crime or owes some duty to the person in danger. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

Aider or abettor. — The legal definition of the word "aider" is not different from its meaning in common parlance. It means one who assists, supports or supplements the efforts of another. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

The word "abettor" means in law one who instigates, advises or encourages the commission of a crime. Thus the word "abet" may import that one is present at the commission of a crime without giving active assistance. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

To be an aider or abettor it is not essential that there be a prearranged concert of action, although, in the absence of such action, it is essential that one in some way should advocate the commission of the crime. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

While guilty knowledge on the part of the accessory, aider or abettor that the unlawful act is being committed is essential, such knowledge may be inferred from facts and circumstances such as would cause a reasonable man of ordinary intelligence, observation and caution to so believe. Polisher v. State, 11 Md. App. 555, 276 A.2d 102 (1971).

Elements of attempt.

Since an attempt to commit an offense constitutes a common-law misdemeanor, there is no requirement that the goods or chattels actually be obtained to sustain a conviction for attempted false pretenses. Bosley v. State, 14 Md. App. 83, 286 A.2d 203 (1972).

Merger.

Where defendant informed a salesman that he had "plenty of credit" and offered a credit card belonging to another, in an attempt to obtain two watches, his convictions under this section and § 551A of this article merged. Bosley v. State, 14 Md. App. 83, 286 A.2d 203 (1972).

Indictment.

An indictment which completely omitted the element that any chattel, money, or valuable security was obtained by the false pretense, failed to allege one of the essential elements of the offense and thus did not charge an offense, denied the court jurisdiction, and rendered the conviction thereunder void. Dunphy v. State, 13 Md. App. 671, 284 A.2d 631 (1971).

What State must prove.

In accord with 1st paragraph in original. See Davis v. State, 18 Md. App. 378, 306 A.2d 620 (1973).

In a prosecution for false pretenses, the State is required to offer evidence showing that the accused falsely represented a past or existing fact. Davis v. State, 18 Md. App. 378, 306 A.2d 620 (1973).

Telephone conversations properly admitted.—In a prosecution under this section it is permissible to admit telephone conversations where they were admitted for the fact that the messages were received and were relied upon and constituted a link in the chain of facts tending to show that defendant participated in a false pretense. Dennett v. State, 19 Md. App. 376, 311 A.2d 437 (1973).

Evidence held sufficient.

Defendant could be convicted under this section where the evidence is clear that goods, falsely represented as being in existence and ready for immediate delivery, were paid for in reliance but not delivered. Dennett v. State, 19 Md. App. 376, 311 A.2d 437 (1973).

Evidence held insufficient.

In accord with original. See Carey v. State, 19 Md. App. 695, 313 A.2d 696 (1974).

Applied in Garner v. State, 16 Md. App. 353, 297 A.2d 304 (1972); Maloney v. State, 17 Md. App. 609, 304 A.2d 260 (1973).

ARTICLE 42-1396h United States Code
(Section 1909 Public Law 92-603)

"(a) Whoever-

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

"(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

"(b) Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this title and who solicits, offers, or receives any-

"(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

"(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

"(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing home, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a misdemeanor and upon conviction therof shall be fined not more than $2,000 or imprisoned for not more than 6 months, or both."

"(d) The provisions of amendments made by this section shall not be applicable to any acts, statements, or representations made or committed prior to the enactment of this Act.

CHAPTER IV

PROCEDURES FOR REFERRAL OF CASES

AND

CASE ASSIGNMENT CONTROL

Chapter IV

Fraud Referrals of Cases and Case Assignment Control

Referrals

The Division of Field Investigation can receive referrals for possible investigative assignment from the following sources:

(1) Department of Human Resources (DHR)

(2) Utilization Review DHMH

(3) Public Complaints

The following comments will be a discussion of these sources:

At any time any employee of DHR finds that a person (s) has received or attempted to receive, from DHR assistance for which he (she) was not eligible, this employee must immediately report this to his immediate supervisor. Possible or alleged fraud may also be received by DHR from the wage screening program and through the efforts of Quality Control. Upon receipt of the information that possible fraud exists, a summary of this possible fraud must be prepared with pertinent attachments and forwarded to the Chief of Field Investigation for possible assignment for investigations.

A regular program of utilization review is being developed. When such a review is conducted by the Division of Health Services, MACA and possible fraud is detected the pertinent information is submitted in summary with attachments to the Chief of DFI for possible investigation.

From time to time we receive complaints from a citizen regarding specific recipients of Assistance. Such complaints should be prepared according to guidelines and forwarded to Chief of DFI. Investigators receiving such complaints must not conduct an investigation until authorized by Division Chief. After review by Division Chief and/or his staff and determination that these are legitimate complaints, investigation will be requested through regular case assignment methods.

Case Assignments and Case Control

Case assignments to investigators will be made by the Chief of the Division of Field Investigation. No case is to be investigated prior to an authorized assignment. Upon receipt of case assignment with case folder and case status check list the investigator starts the status check list. On the last working day of each month the investigator will submit to the Division Office (Chief of Field Investigation) a list of all cases assigned by name, in alphabetic order, and file number(s), showing opposite each case name and status completed as of that date.

Name	File No.	Status
Ball, Jane	W694	C
Jones, Sue	W432	E
Smith, Bessie	W596	B

The status check list should always be the top page of the case file and should remain in case file when returned to Division Office. Status check lists must be kept up-to-date at all times.

Each invesitgator will be scheduled for a complete file review of cases assigned, by the Chief of Field Investigation. This schedule will be given to the investigators on the 1st working day of each month.

Prior to date of scheduled file review the investigator will familarize himself with all aspects of his investigations to date and be prepared to discuss each case in detail and his plan for subsequent investigation.

All case files assigned investigator must be maintained in an orderly, chronological manner and all his investigative notes must be dated and initialed on date notes were taken.

CASE STATUS CHECK LIST

File Number Name Program

Code		Status	Date	Initial
A		Case assignment received		
B		Case assignment reviewed		
C	*	DHR case file reviewed		
D		Investigation completed		
E		Report write-up completed		
F		Submitted to Chief Investigator		
G		Referred to SA		
H		Recommendation to drop case		

Comments:

Date of Disposition:

_____

Signature of Reviewing Officer

* Optional if needed.

CHAPTER V

FIELD INVESTIGATIONS

Chapter V

Investigations

Investigation is a step by step operation completed by patient inquiry or observation. It is also a procedure to track or trace mentally or to search into, examine and inquire with accuracy and care. Investigation also involves the taking of testimony and the collection of evidence. The so-called "Scientific Method" of investigation follows 5 basic steps: (1) Define the issue; (2) Isolate the issue from surrounding matters; (3) Plan and develop a solution; (4) Place the plan into action; (5) Follow-up to see if desired results are achieved.

Investigations conducted by this Division are more suitable for use of this "Scientific Method". A systematic inquiry into facts surrounding Assistance Fraud and assembling these facts in report form is the primary investigative task assigned to this Division.

As an investigator, you should always keep in mind that you are seeking facts and that you should never investigate with your mind oriented toward prosecution or defense. Your goal should always be to obtain all pertinent and related facts and report these facts in a complete, concise, logical and unbiased manner.

To accomplish the goal as set forth above, an investigator must know where to look for his information. He must also have a good knowledge of the rules of evidence if his investigative report is to be used in a legal matter. An investigator's work is never completed until the paper work is done. Therefore, he must be able to effectively communicate his findings in a written report in a manner to finalize his investigative effort.

The following are to be used as guidelines in the investigator's search for the facts, however, each investigator must develop his own technique, expertise, professional knowledge and sources of information.

In the Scientific Method of investigation as mentioned above we should:

1-2 Define the issue and isolate from surrounding matters.

This is accomplished by a thorough desk review of the case assigned. Ask yourself the question, "Why was this case referred for investigation?" If the reason is not clear make arrangements to review the entire case record maintained by the Department of Employment and Social Services (DESS). Make sure the complaint is a legitimate complaint and not the result of agency error and/or a misunderstanding.

3. Plan and develop a solution.

   This procedure is also accomplished through desk and file review. Consider what must be done to prove or disprove the allegation. What field contacts must be made? What evidence is necessary? What is the source of the evidence?

4. Place the Plan into action.

   This is accomplished by your field investigations, assembling witnesses and collection of evidence. Upon completion of the investigation you must assemble your findings into a narrative report ready for referral to the proper State's Attorney.

5. Follow-up to see if desired results are achieved.

   Review your entire investigative effort according to your plan of action. Has my plan accomplished our goals? Was the issue proven or disproven? If issue proven are you ready to carry issue to court?

Evidence

To accomplish our over-all goal the investigator must, in addition to knowing where to look for his information, also have a good knowledge of the rules of evidence if his investigative reports and efforts are to be used in a legal proceeding.

The investigator considers the different types, forms and test of evidence. The following is a brief discussion of evidence which is intended only as a starting point for the investigator's consideration of the subject.

There are two types of evidence, direct and circumstantial.

Direct evidence is defined as: evidence which tends to directly prove a fact in issue (i.e., eyewitness account). Circumstantial evidence on the other hand is defined as: evidence which tends to prove a fact or facts from which the fact in issue can logically be inferred (i.e., a client's drivers license and employment records shows a residence address that is the same. It is therefore established that the client resides at that address.)

Either type is acceptable in court of law, however, in most cases more circumstantial evidence is required to establish guilt beyond a reasonable doubt. It is entirely possible and legally feasible to establish guilt on circumstantial evidence alone. Assistance fraud cases are primarily based on circumstantial evidence.

Evidence can present itself in three forms:

1. Real evidence - that which has physical character such as a weapon used in a crime.
2. Oral evidence - spoken testimony given by a witness.
3. Documentary - a written, recorded, micro-filmed, photographed, etc. document.

A case may contain all or any combination of the three forms of evidence.

In order to use in court, evidence must pass three tests depending on its type and form:

1. Authenticity - This is always the paramount consideration. The following questions must be satisfied:

    a. Age of document or date it was established.
    b. Purpose of its establishment. Would there be any reason for falsification?
    c. Basis for record - Was proof requested originally? Who provided information for the document?
    d. Formality of the document - Was it prepared under oath? Seal? Witnessed? Penalty for false statement?
    e. Chain of custody - Who has had it in his possession? Why?
    f. Method of originating or recording information thereon.

It will often be necessary to use an expert witness (handwriting) or custodian of the record to establish authenticity.

2. Relevancy - Whether or not the evidence is related to the matter in issue. For example, when using a birth certificate to establish age you must show that age of the person in question is related to the charges in the case and that the case was developed or based on an erroneously stated age.

3. Competancy - When the question of competancy arises, several things must be considered:

   a. Best Evidence Rule - This rule states that the original sources or next closest source of evidence should always be used when possible.

   b. Establishment of Character and Truthfulness on Part of Witness giving Oral Testimony. It would be rather hard to place much confidence on the testimony of a person who himself had been convicted of a crime involving fraud.

There are many exclusionary rules to be considered which prohibits the use of evidence in legal matters. Some of them are:

1. Hearsay - any evidence based on something the witness has heard someone else say rather than on what he has himself seen or experienced.

2. Privileged Communication - communication between a doctor and patient which is the result of professional duties and services, communication between husband and wife, communication between clergy and individual which is in official scope of duties and service.

3. Opinion evidence - opinions are never allowed except in case of court established or recognized "expert witness".

The above discussion of evidence is by no means a complete coverage of so complex an area as evidence. It does, however, set forth pertinent points to use as guidelines and opens the door for further research by the investigator if he finds it necessary.

Field Contacts

Prior to discussing field contacts by the investigator, it is necessary to state the importance of proper identification. The only acceptable means of identifying yourself to a contact is by use of your identification card. Under no circumstances will any investigator of this division perform any contact or official act unless he has on his immediate person his identification card and can produce it upon request or as the situation dictates.

The calling, or business card is not a substitute for proper identification. Use the business card only for the purpose of requesting to be recontacted or upon request of the person contacted.

It has been found that personal "face to face" contact with employers, business establishments and governmental agencies is the most effective method of obtaining the necessary information desired. Use of the telephone should be only for arranging appointments. Maintaining a courteous manner at all times is necessary. It must be remembered that the investigator is requesting the information and a demanding attitude will alienate the contact and result in wasted time and effort. In the event the contact has the necessary information but denies the investigator access without a subpoena he should discuss the problem with the Chief Investigator prior to requesting the State's Attorney to issue a subpoena.

In the event the employer or other contact does not have a local address and records are out of state, the investigator should evaluate how vital this information is to proving fraud before preparing a letter to send to the out of state business. If the information desired is of significance, prepare letter for signature of the Chief of the Division or Chief Investigator.

It may be necessary to interview neighbors, friends and family or other persons who possess information concerning the client or his location. Care should be taken to release as little information, concerning the purpose of the inquiry, as possible. Should the persons being interviewed begin to incriminate themselves, they should be given warnings

and an explanation of their rights. Only sound judgement on the part of the investigator can determine the exact time when such action becomes necessary. To act too quickly can close a source of information.

Signed Statements

During the course of investigation of a Provider of Medical Assistance, it will most likely be that recipients of the service provided must be interviewed to determine if they received the service and if the service was satisfactory.

Accurate notes should be taken and dated. Often, it will be necessary to take a signed statement from the recipient. The following guides to the investigator should be followed in as far as possible:

1. Attempt to have person write statement in own handwriting.
2. If unable to do No. 1, investigator will write statement, but have person interviewed write the last paragraph in his own handwriting.
3. If person interviewed cannot write - Investigator will write the entire statement and have the person sign. If signed with X look for an additional witness (neighbor or child of person interviewed if able to read and write).
4. If person cannot read or write investigator will write the entire statement and in last paragraph state: "The above statement was written and read to Jane Doe by John Smith and she stated it was true and correct to the best of her knowledge". Investigator sign.
5. If person is writing his statement, do not dictate to him. Let it be his own statement.
6. If investigator writes statement, be concise and to the point, – DO NOT RAMBLE.

Sample Signed Statement

DATE: November 21, 1973
TIME: 1:45 PM

I, Jane Doe, residing at 425 S. Anywhere Street, Baltimore, Maryland do hereby furnish the following statement to John Smith who has identified himself to me as an investigator of the Department of Health and Mental Hygiene, State of Maryland. No threats or promises were made to me to make this statement. I understand this statement may be used in a court of law and I am willing to testify in a court of law to this statement.

On January 12, 1975, I visited the office of Dr. Jacob Johnson, Dentist, 647 Washington Street, Baltimore, Maryland for my six month check-up. I took my young son, Joey, age 7, with me.

After being examined by Dr. Johnson, he advised that all my teeth were in "good shape" and that all that was needed was cleaning. At no time did he pull any of my teeth or fill any teeth.

Dr. Johnson, after he had completed cleaning my teeth, suggested that he examine Joey's teeth. After the examination, he advised that Joey's teeth were in excellent condition and no work was necessary. He did not fill or pull any of Joey's teeth.

I have read the above statement, consisting of this page and it is true and correct to the best of my knowledge. I have initialed all corrections and have initialed this page.

Signed -- Jane Doe

Witness: John Smith, Investigator, Dept. of Health and Mental Hygiene 4/12/75

During the course of investigating alleged fraud of a recipient of Medical Assistance, the investigator will in many cases interview the recipient.

Prior to beginning the interview and after properly identifying yourself, you should advise the recipient of his rights as set forth in the Miranda case. Each investigator should himself be fully aware of these rights and should carry with him a copy of the rights.

The interview of the recipient should focus on the following points:

1. Determine that suspect recipient is the same individual referred to in the Department of Social Services file and is the individual suspected of alleged fraud.

2. That the suspect recipient did receive Medical Assistance paid for by the Medical Assistance Programs.

3. That the signature on the application or reconsideration application is the signature of the suspect recipient.

4. Confront the suspect recipient with facts he withheld information or gave false statements to the Department of Social Services. Efforts should be made to obtain an admission from the suspect recipient that he did have employment, earnings or assets which were not reported to the Department of Social Services. Make no threats or promises to obtain this admission.

The preceding interview points are to serve as guidelines and it is expected that each investigator does possess interview techniques and knows when an area should be pursued further.

If possible the suspected recipient should be encouraged to furnish a signed statement of his admissions. When obtaining a signed statement the following should be followed:

1. Attempt to have recipient write statement in his own handwriting.

2. First paragraph should contain fact recipient's rights had been explained.

3. If unable to do No. 1, investigator write statement as dictated by the recipient - If possible have recipient write at end of statement that it is true and correct to the best of his knowledge.

4. If recipient interviewed cannot write, the investigator will write the statement and have the recipient sign. If unable to sign name, have him make an X and have an additional witness (neighbor or child of recipient who is able to read and write).

5. If recipient is writing statement, do not dictate to him. Let it be his own statement.

6. If investigator is writing statement, be concise and to the point - DO NOT RAMBLE.

Sample Signed Statement - Recipient Suspect

DATE: January 10, 1975
TIME: 1:45 PM

I, Jane Doe, residing at 425 S. Anywhere Street, Baltimore, Maryland do hereby furnish the following statement to John J. Jones, who has identified himself to be an investigator of the Department of Health and Mental Hygiene, State of Maryland. No threats or promises have been made to me to make this statement. I have been advised by Mr. Jones that I do not have to make any statement and that any statement made by me can be used in a court of law. Mr. Jones advised me that I had the right to contact an attorney and have my attorney present during the interview; if I did not have an attorney one would be appointed by the courts; I have the right to stop the interview at anytime to consult with my attorney. I waive these rights at this time.

On June 1, 1974, I applied for Medical Assistance by submitting an application to the Department of Social Services, Baltimore, Maryland. On this application, which I signed on June 1, 1974, I indicated I was unemployed and was in need of Medical Assistance. Based on my answers to questions on the application and questions asked me by the Social Worker, I was approved for Medical Assistance and received my medical assistance card on or about June 15, 1974.

At the time of my application, I was employed at S & R Soda Shoppe located at 1721 East Street, Baltimore, Maryland and was receiving $80.00 a week plus approximately $20.00 per week in tips. I did not report this employment or earnings on my application or to my social worker because I knew that if I did report the employment I would be turned down for medical assistance.

I used my medical assistance card on July 5, 1974 at Mercy Hospital, Baltimore, Maryland where I had gone as an inpatient to have an operation on my leg.

I have read the above statement consisting of this page, and it is true and correct to the best of my knowledge.

Signed — Jane Doe

Witness: John J. Jones, Investigator 1/10/75

Sources of Information

The following sources of information can be utilized to gather evidence which may sustain a charge of Medicaid fraud.

This listing is by no means complete and is intended only to point out the various resources available to an investigator. Additionally it is not intended to apply to each and every case of Medicaid fraud. Rather, it is intended to be used as a check list to refresh one's memory when investigating various types of recipient and/or provider fraud.

This list is broken down into areas wherein information supplied to obtain eligibility by a recipient may or may not be truthful. The areas mentioned herein are areas regarding a recipient's income and assets which are usually areas of possible fraud.

1. Real Estate (Home and Other)

When the case record or the recipient's statement discloses ownership of property, the recipient will generally have in his possession documents to provide the verification required.

In those instances in which the recipient does not have documents or in which the client denies ownership, the investigator will find it necessary to go beyond the client's statement to establish the possession or non-possession of this resource.

The investigator should where possible, routinely clear the client's case for property ownership. Clearance for property ownership can be made through county courthouse records.

When the tax assessor's office list of property owners is filed in alphabetical order, a routine clearance is relatively easy.

In some jurisdictions, records are filed based on a legal description of the property.

It would be advisable to develop a working knowledge of the system of tax billing and collection, in addition to an understanding of property title search procedures.

a. Document or Other Record Generally Available from the Client

1) Deed
2) Sales Agreement
3) Mortgage
4) Estate Data
5) Articles of Agreement
6) Real Estate Tax Receipts
7) School Tax Receipts
8) Income Tax Return

b. Verification Information from Other Sources

1) Courthouse Records
2) Tax Records
3) Real Estate Tax Transfer Division
4) Title Search
5) Utility Company Records
6) Charge Account or Charge Account Application Records
7) Municipal Building Inspection Compliance Records
8) Municipal Fire Code Records

2. Life Insurance

When the client declares ownership of insurance, he will generally be able to present the policies to the investigator for verification of the resource. The investigator will evaluate the policy to determine if its value conforms to the State's requirements. If the investigator is unable to determine the value of the insurance policy, the issuing company can furnish data as to the policy's cash surrender value. Of those instances in which the client denies ownership of insurance, the investigator can check local insurance agencies or brokers to establish the non-ownership of insurance. Perceptive interviewing can provide clues for further exploration. To make such exploration as meaningful as possible, the investigator must carefully evaluate which insurance companies might be a potential carrier for the client, i.e., by inquiring and checking sources of both existing and non-current policies for auto, home, personal property, and policies held by other family members, to furnish leads as to what brokers and companies to contact.

a. Document or Other Record Generally Available to the Client

1) Insurance Policies
2) Burial Reserve Agreements
3) Burial Agreement with Funeral Director

b. Verification Information from Other Sources

1) Clearance with Insurance Company
2) Insurance Payment Book
3) Clearance with Insurance Agent
4) Employer's Insurance Records
5) Lodge, Club, or Fraternal Organization Records
6) Funeral Director
7) Relatives and Friends Holding Policies for Client
8) Union Records
9) Veterans Administration Records
10) Credit Applications or Charge Account Applications

3. Savings, Cash, Investments

When the client declares ownership of these resources he will generally have documents in his possession to establish ownership and value of the asset. The investigator must determine the value of the asset. The investigator must determine the value of the asset in relation to the review date. If the client does not have in his possession documents to establish ownership and value of the asset, the investigator can obtain this information from the custodian of the funds or the investment organization.

For those situations in which the client denies ownership of these assets, the investigator must establish a basis for a decision of non-ownership. Again, careful exploration of possible or potential resources through perceptive interviewing can provide valuable clues for further investigation. The investigator may evaluate the client's past circumstances and present living standards to determine the possible existence of these assets. The investigator should selectively use one or more verification of nearby neighborhood banks to establish that the client does not have accounts at these institutions. The investigator may inquire where the client cashes his check, or what bank or institutions were used for past transactions, or what source of financing was used for major purchases. Thus, through a thorough and well-directed interview, the investigator can obtain leads for verification sources to establish ownership or non-ownership of this type.

Some State plans require identification of ownership and evaluation of the value for motor vehicles. The primary verification for ownership is clearance with the State agency responsible for the registration of motor vehicles. This agency can establish whether the client owns a vehicle. In some states, this agency can also furnish evaluative data on the vehicle. Information available would include the purchase of the vehicle, encumbrances against the vehicle, and the name of the organization financing the purchase. This will aid in evaluating the effect of car ownership or eligibility. The State motor vehicle registration agency can also be used to establish non-ownership of a vehicle.

The "blue book" of car valuations can also be used to establish the value of motor vehicles. Other sources which can be used to establish valuation are car dealers who can give an approximate valuation based on make, year, and model of the vehicle.

a. Document or Other Record Generally Available from the Client

1) Bank Books
2) Stock Certificates
3) Bond Certificates
4) Mortgages
5) Notes
6) Securities
7) Credit Union Statements
8) Savings and Loan Statements
9) Bank Statements
10) Car Title and Registration
11) Auto Financing Data

b. Verification Information from Other Sources

1) Bank Records
2) Stock Brokers
3) Credit Union Records
4) Judgment and Lien Records
5) Savings and Loan Records
6) Credit Applications
7) Charge Accounts Applications
8) Credit Accounts
9) Motor Vehicle Registration

4. Disposal of Property

The investigator will have to consider the type of property (real or personal), the valuation of property, consideration received for the transfer, and time period of the transfer. Since the eligibility factors vary on a State-by-State basis, the investigator must be knowledgeable about the State provisions covering property disposal.

In those situations in which the client acknowledges that property was transferred, the client and the transferee will generally have some type of documentation to provide the necessary verification. For these situations, establishment of the facts involved in transfer is fairly routine.

Courthouse records can be cleared to check on the transfer of real property. The Docket Books list by both Grantor and Grantee alphabetically in the index. Thus, the investigator can check real property transfer utilizing either party to the transaction.

When the client advised that he has not transferred property within the time limits of the State regulations, the investigator evaluates the client's circumstances, past and present, and checks court transfer records to reach a basis for supporting a decision on disposal of property.

a. Document or Other Record Generally Available from the Client

1) Transfer Papers
2) Deed
3) Mortgage
4) Articles of Agreement
5) Sales Agreement
6) Real or Personal Property Tax Statements
7) State and Federal Income Tax Statements
8) Cancelled Checks or Receipts

b. Verification Information from Other Sources

1) Court Records
2) Real Estate Tax Stamps
3) Tax Records
4) Attorney's Records
5) Real Estate Agent or Broker
6) Stockbroker
7) Utility Company Records
8) Motor Vehicle Registration

5. Earnings

The primary verification for declared earnings is the employee's pay record of wages received from his employer (pay stubs, etc.). When the client does not have these verifications available, the investigator can obtain this information from the employer's records. The verification of declared earnings can generally be accomplished through these sources with relative ease.

When the client states that he has no earnings, verification becomes more difficult. The investigator must go beyond the statement of the client to reach a basis for a decision that the client does not have earnings. Information obtained from contact with individuals while verifying other elements of eligibility, e.g., from relatives, school officials, landlords, etc., may show that the client is frequently absent from the home. This may be an indication of the client's full or part-time employment.

a. Document or Other Record Generally Available from the Client

1) Pay Stubs
2) Pay Envelope
3) Employee's W-2 Form
4) Wage Tax Receipts
5) Income Tax Return - State and/or Federal
6) Self-Employment - Bookkeeping Records of Client
7) Sales and Expenditure Records

b. Verification Information from Other Sources

1) Employer's Wage Records
2) State Form for Clearance of Earnings from Employment
3) Statement from Client's Employer
4) Employment Security Office
5) Occupation Tax Agency
6) Local Wage Tax Agency
7) State Income Tax Bureau

6. OASDI and Other Pensions and Benefits

The primary verification for OASDI benefits will be the Beneficiary Data Exchange (BENDEX) System, i.e., the automated communication system between State welfare agencies and SSA in Baltimore regarding Social Security benefits. SSA Form 1610 (Request for Information by State Public Assistance Agency) should be used when BENDEX information is not available, or when special circumstances warrant, the investigator may check directly with the Social Security District Office to obtain OASDI benefit information. These offices have microfilm records of payments to beneficiaries, and will generally furnish the benefit data by a print-out. The clearance may be made by Social Security number and/or name.

A routine check for OASDI benefits should be made for all cases when the deprivation of parental support factor is death or incapacity. Benefits other than

OASDI, such as unemployment compensation, workmen's compensation, Veteran's benefits, etc., can be cleared with the agency responsible for payment of the benefit. In most States there is an established verification procedure for checking these items. When the client states that he receives these benefits, clearance should be made to establish that the declared benefit amount is correct.

When the client states that he does not receive a benefit, the investigator should evaluate this statement in terms of the client's background, past work history and present circumstances. The use of skilled interviewing techniques can elicit relevant background information which can furnish leads as to the possible receipt of benefits. As an example, review of the client's employment record may indicate possible eligibility for a company retirement pension, past union membership could indicate possible benefits from that source, etc. The investigator must establish a basis for decision as to the non-receipt of benefits more substantial than the client's denial of the resource. The worksheet recording should clearly state the basis for the decision.

The investigator should clear the receipt or non-receipt of Veteran's benefits through the Veterans Administration for appropriate cases. When relevant, Railroad Retirement benefits can be cleared through the Railroad Retirement Board on that agency's forms, which must be signed by the beneficiary.

a. Document or Other Record Generally Available from the Client

1) OASDI award letter
2) Benefit Payment Check
3) Unemployment Compensation Award Letter
4) Pension Award Notice
5) Veterans Administration Award Notice
6) Correspondence on Benefits
7) Income Tax Record – State and Federal
8) Railroad Retirement Award

b. Verification Information from Other Sources

1) BENDEX System
2) Social Security (Form SSA-1610)
3) Social Security District Office Files
4) Bureau of Employment Security – Unemployment Compensation Section
5) Employer's Records
6) Union Records

7) Workmen's Compensation Records
8) Veterans Administration
9) Lawyer's Records
10) Insurance Company Records
11) Lodge, Club, or Fraternal Organization Records
12) Personal or Income Tax Records
13) Railroad Retirement Board Records
14) United Mine Workers Union (Black Lung Benefits)
15) Social Security Administration (Black Lung Benefits)
16) Eyler Wage Screening

7. Support Payments and Contributions

The primary source for verification for declared support payments and contributions is contact with the person making the contribution. When support payments or contributions are made through a third party, such as a Court or probation office, verification can be made through that agency. The investigator must be alert to the effect of timing and amount of payment in relationship to the review date. When the client advises that the family does not receive support payments and the whereabouts of the person liable for support is known, the investigator should verify non-receipt through contact with the person liable for such payments.

The investigator must bear in mind the various degrees of liability for support under the State plan. Also, the investigator must consider the possibility of support payments on contributions being made on a voluntary basis without legal liability for such contributions. In cases where the absent parent's address is not known, the investigator will probably have taken steps, under Deprivation - Absence, to establish the location of the parent. If the absent parent is located through this process, availability of support payments as of the review date can be determined. In those situations in which the client states that the family receives no support payments, and the legally liable relative's whereabouts are unknown, the investigator must record the leads pursued as basis for his decision that support payments are not received.

a. Document or Other Record Generally Available from the Client

1) Divorce or Separation Papers
2) Court Order
3) Contribution Check
4) Support Agreement
5) Correspondence on Support Payments

b. Verification Information from Other Sources

1) Court Record
2) Probation Office Record
3) Statement of Person Making Contribution
4) Lawyer's Records
5) Cancelled Checks of Person Making Contribution
6) Receipts for Contribution
7) Income Tax Returns
8) Employer's Records of Attached Wages

8. Other Income

This element covers all Need - Income not enumerated under its own individual income element. The principal items are income in kind, income derived from rental or lease of property or from property rights, money from friends on a regular basis, free shelter, and income from other sources.

The type of verifications necessary to reach a definitive conclusion will be conditioned by the type of resource available to the client. As "other income" covers all income not enumerated under individual elements, the investigator will evaluate the client's situation to ascertain the possibility of an additional source of income.

When the client discloses income under this element, he will generally have documents or papers to identify the source and amount. The investigator can contact the person making payments to the client to verify the purpose and the amount of money paid to the client.

The investigator can establish through a process of elimination, the possession or non-possession for most items. To illustrate, verification of client's shelter costs eliminates the possibility of free shelter. Determination that the client does not own property eliminates the possibility of rental income, lease rights, or income from property rights.

a. Document or Other Record Generally Available from Client

1) Rental Agreement or Lease
2) Receipts for Service Provided (Income In Kind)

b. Verification Information from Other Sources

1) Rent Receipts of Tenant, Roomer, or Boarder

2) Statement of Person Providing Income In Kind, Goods, or Financial Aid

3) Receipts, Agreements, Leases of Person Paying Monies to Client Under this Element

CHAPTER VI

INVESTIGATIVE REPORT

Chapter VI

Investigative Reports - Recipient Fraud

Purpose:

The purpose of the narrative report is to provide the State's Attorney with a summary of our Fraud investigation and transmit to him the related evidence to support our referral.

Distribution:

Original and 1 copy to State's Attorney

1 copy in case file

Heading:

State of Maryland
Department of Health and Mental Hygiene
Medical Assistance Compliance Administration
Division of Field Investigation

Date:

List date of report in the right top corner. This date should be the date report is completed in final form ready for referral to the State's Attorney.

Case Identification:

Investigative report in the case of Jane Doe

MA No. 11 digit no.

Alleged Offense:

Violation of Article 27, Section 230A of the Annotated Code of Maryland (or other violations as set forth under Chapter III - Maryland Law)

Synopsis:

A brief summary of the investigation setting forth the alleged offense and proof of the offense with the amount of overpayment and benefits resulting from the fraud.

Details:

1. Set forth identification of client including:
   a. Name (1st, initial, last)
   b. Residence address
   c. DOB
   d. Social Security No.
2. Information regarding length of time on program - and 1st date of approval.
3. To end

Remainder of report will be a chronological series of events to prove the alleged fraud. At end of an event list No. of witness and/or evidence document.

Signature:

Investigator will sign the report in the lower right hand side of the last paragraph of the details.

Attachments:

Witness list - See attached.
Evidence - to prove case - listed and assembled as referenced in details of report.

Special Instructions:

1. Spell out all names such as Medical Assistance Program, Aid to Families with Dependent Children, Division of Employment and Social Services, etc.
2. Avoid making a direct charge - use "alleged fraud, suspected fraud, alleged false statement", etc.
3. If exact dates cannot be established by evidence, use term "on or about".
4. Do not include personal opinions anywhere in report.
5. In the Medical Assistance Program where client does not receive actual money for care, indicate this as "Medical Assistance Benefits".
6. Do not make a statement of fact unless supported by a witness and/or an enclosure.
7. Place name and Medical Assistance number in the top right hand corner of all pages of the report except 1st page where name and number is listed under case identification.

Sample Investigative Report:

State of Maryland
Department of Health and Mental Hygiene
Medical Assistance Compliance Administration
Division of Field Investigation

Date: October 31, 1974

Investigative report in the case of Joan B. Rogers
MA No. 30-096784-350

Alleged Offense:

Violation of Article 27, Section 230A, Annotated Code of Maryland

Synopsis:

Joan B. Rogers has been receiving Medical Assistance from the State of Maryland, Department of Health and Mental Hygiene from September 1972 to July 1974. As a result of Joan B. Rogers' failing to report her employment by Union Memorial Hospital, Baltimore, Maryland for the period January 10, 1973 through May 30, 1974; failure to advise Department of Employment and Social Services of a resource of $5,000.00 received in March 1973, she has received or attempted to receive Medical Assistance Benefits in the amount of $1,000.00 for the period of January 1973 through May 1974 to which she was not legally entitled.

Details:

Joan B. Rogers, birthdate June 11, 1935, whose last known address was 429 West 21st Street, Baltimore, Maryland 21211, Social Security number 273-35-0658, is the subject of this investigative report.
(Witness 1 and Enclosures A and B)

On August 16, 1972 Joan B. Rogers applied to and was approved from the State of Maryland, Department of Employment and Social Services for Medical Assistance effective September 1972.
(Witness 1 and Enclosures A and A1)

On August 16, 1972 as part of her application for Medical Assistance Joan B. Rogers indicated she was not gainfully employed and that she had no assets or resources. She indicated that she would advise the Department of Employment and Social Services if there was any change to the information she furnished on the application. On January 10, 1973 Joan B. Rogers began working as a nurses' aid at the Union Memorial Hospital, Baltimore, Maryland and earned a gross income of $210.00 bi-weekly. She failed to report this employment and income to the Department of Employment and Social Services.
(Witness 1 and 2, Enclosure A)

On April 26, 1974 as a part of a redetermination of eligibility for Medical Assistance, Joan B. Rogers indicated she was not gainfully employed and that she had no assets or resources. She indicated she would advise the Department of Employment and

Social Services if there were any changes to the information furnished during the redetermination. On January 10, 1973 Joan B. Rogers, Social Security number 273-35-0658 began employment as a nurses' aid at the Union Memorial Hospital, Baltimore, Maryland and was so employed until May 30, 1974 and earned a gross salary of $210.00 bi-weekly. This employment and earnings was not reported to the Department of Employment and Social Services.

(Witness 1 and 2, Enclosure B)

On March 10, 1973 Joan B. Rogers received from the estate of her deceased father, William J. Rogers, the sum of $5,000.00 less taxes, as set forth on page 64, Paragraph 10 of the records of Probate Court, Baltimore County, Maryland. This sum was not reported to the Department of Employment and Social Services during her redetermination for eligibility on April 26, 1974.

(Witness 1 and 3, Enclosure C)

Joan B. Rogers received or attempted to receive $1,000.00 in Medical Assistance Benefits during the period of January 1973 through May 1974 to which she was not legally entitled.

Signed: John J. Jones
Investigator

WITNESS LIST

Case No. _____

Defendant _____

1. Name: _____ Phone: _____

   Address: _____

   Will Testify To:

   Subpoena may be served: _____

2. Name: _____ Phone: _____

   Address: _____

   Will Testify To:

   Subpoena may be served: _____

3. Name: _____ Phone: _____

   Address: _____

   Will Testify To:

   Subpoena may be served: _____

4. Name: _____ Phone: _____

   Address: _____

   Will Testify To:

   Subpoena may be served: _____

Chapter VI

Investigative Reports - Provider Fraud

Purpose:

The purpose of the narrative report is to provide the State's Attorney with a summary of our fraud investigation and transmit to him the related evidence to support our referral.

Distribution:

Original and 1 copy to State's Attorney

One (1) copy in case file

Heading:

State of Maryland
Department of Health and Mental Hygiene
Medical Assistance Compliance Administration
Division of Field Investigation

Case Identification: Cover Sheet

Report of Investigation of Alleged Provider Fraud in invoices Submitted for Payment Under the Medical Assistance Program.

Provider: John J. Doe, DDS
1600 W. 29th Street
Baltimore, Maryland 21211
Medical Assistance Provider Number 4-01684
Case File Number - V-1000

Report By: Gumm S. Sleuth
Investigator
Division of Field Investigation
Medical Care Programs
Department of Health and Mental Hygiene

Date - July 4, 1976

Title Page:

1st page of report should be a duplication of cover sheet - Case Identification..

Contents:

The contents of the report should be so arranged to give a brief outline of the contents of the report.

Background and Operation of Medicaid:

This section of the report should give a brief background and operational procedures of the Maryland Medical Assistance Program (Medicaid).

Synopsis:

A brief summary of the investigation setting forth the alleged offense and proof of the offense with the amounts of overpayment made by the Medical Assistance Program.

Predication:

A brief statement of how and why this investigation was instituted.

Details of Investigation:

This section should give clear and concise results of your investigation in chronological order with evidence to prove or disprove the allegation of fraud.

Appendix:

Any documents or evidence needed to clarify various statements and evidence utilized in the report.

(SAMPLE REPORT SEE - FILE # V-49)

CHAPTER VII

REFERRAL TO STATE'S ATTORNEYS

AND FOLLOW THROUGH TRIAL

Chapter VII

Referral to State's Attorneys and Follow Through Trial

When the Division of Field Investigation investigator has completed his investigation, relevant to a case and has collected all of his evidence, he should review his workpapers and his final report to be sure he has not left any question unanswered and if he is satisfied, he should submit his report to the Chief of Field Investigation for review.

After review by the Chief of Field Investigation and he is satisfied that there are enough facts to support a charge of fraud it is time to refer the case to the appropriate State's Attorney for his prosecutive opinion.

The case will be referred to the State's Attorney only by the Chief of Field Investigation or his designated representative.

Procedural steps in referring of cases and the final filing by the State's Attorney may vary in the 23 counties and Baltimore City. It is the responsibility of the Chief of Field Investigation or his designated representative, through liaison with various State's Attorneys, to establish proper procedures for individual State's Attorney districts.

It is the responsibility of the Chief of Field Investigation or his designated representative to provide the State's Attorney, as prepared by the investigator, a detailed listing of evidence, the chain of custody and proposed use in supporting the charges. State's Attorney must also be provided a detailed list of witnesses who can testify or present various pieces of evidence to support the charges.

If the State's Attorney files the case, either by Information or Indictment, it will be the responsibility of the Chief of Field Investigation or his designated representative to follow-up on the status of cases from date filed to final judication.

A good liaison program with the State's Attorneys and clerks of courts can enhance our efforts to obtain our desired results.

Presenting the State's Attorney a quality product, a good briefing and any assistance which does not exceed our authority will help us to reach the goals desired.

CHAPTER VIII

COURT PROCEEDINGS AND COURTROOM BEHAVIOR

Chapter VIII

Court Proceedings and Courtroom Behavior

The following discussion may be helpful for Investigators who may appear in court as a witness in a Medical Assistance Fraud case.

A. Your Role as a Witness

As a prosecution witness you can expect that your testimony will bring out facts which will result in the defendant's conviction. This does not mean, however, that you are personally or professionally prejudiced against the defendant. It means that you have information or material in your posession which is needed by the State's Attorney to develop his case.

The State's Attorney will be the first to question you while on the witness stand. This phase of the questioning is known as "Direct Examination". When the State's Attorney has completed his questioning, the Defense Attorney will then question you. This is known as "Cross Examination". The Defense Attorney can only question you on matters covered in the direct examination and he may not open new avenues. He may, however, ask questions which will establish your credibility or attempt to blemish your credibility. Depending on the circumstances the State's Attorney may wish to question you again on "Redirect" to clarify, amplify or refute any points made in either his first questioning or on the cross examination. Again, depending on the circumstances the Defense Attorney may "Re-Cross" for the same purpose used for the redirect questioning by the State's Attorney, to help his client's case.

Most of the time you will be excused after your one session on the stand, however, there are occassions when the State's Attorney may break your testimony into two or more parts by having you "excused subject to later recall". The breaking up of your testimony would be to make a more logical presentation of the case.

B. Preparation for Appearance in Court

When the State's Attorney has made a decision to proseeute a medical assistance

fraud case he may wish to confer with you on your proposed testimony prior to appearance in court. This is perfectly legal and will give you a good idea of what testimony will be expected of you.

You may also receive a request and/or a subpoena to appear in the Defense Attorney's office to discuss the case. If this happens immediately notify the State's Attorney. Do not discuss the case with anyone other than the State's Attorney, or the Chief of Field Investigation. If a subpoena is received from the defendent's Attorney notify State's Attorney so he can arrange to be present at time of the defendent's questioning.

Before the day of the trial or your appearance as a witness you should familiarize yourself completely with the case and the essence of your testimony. Assemble any documents that you will testify to and be able to refer to them on the stand without fumbling around while testifying.

C. On the Witness Stand

When you are called to testify you will be summoned by the court bailiff who will escort you into the trial area. Before you take the stand you will be "sworn in" by the clerk of the court. He will ask you to swear that in the proceedings presently before the court you will tell the whole truth and nothing but the truth. You will respond simply, "I do", and then take your seat on the witness stand.

The State's Attorney will then proceed to ask you the questions which have been previously discussed with you. Answer these questions in the manner in which you have previously indicated to him you would. Do not try to elaborate, amplify, or explain your answers.

Also, speak in a clear voice, loud enough to be heard by the judge, court reporter and all members of the jury. Address the jury rather than the judge. Above all, reflect a professional attitude, being impartial, not antagonistic to either the State's Attorney or the Defense Attorney, and avoid giving answers which are impertinent or sarcastic. To the lay mind, the court processes are sometimes long, tedious, and

convoluted, so please be patient. Both attorneys know what information they wish to elicit from you and are skilled in bringing it out in a manner which will be acceptable under the rules of evidence. Bear with them.

After your direct testimony has been given, the cross examination by the Defense Attorney begins. Here your previous preparation and knowledge of your case can smooth out what could otherwise be a tortuous and rocky road. It is the Defense Attorney's job to make every effort to refute the prosecution's claims. In attempting to determine if there are flaws in the evidence the State's Attorney has presented, or to gain a more favorable impression, the Defense Attorney sometimes resorts to tactics which are aimed at placing you in an unfavorable position. Another tactic he may employ is to attack the entire Medicaid system. Do not be trapped into attempting a defense of either the system or yourself. It is the State's Attorney's responsibility to make objections when the Defense Attorney gets into areas that are not relevant to the case in question. Maintain your cool, poise, and self-control. Give slow, deliberate answers to questions without any show of emotion. Attempt to explain your answers only if a simple, direct response would be so misleading that it would create a situation which could not be corrected later. Otherwise, the State's Attorney can and will give you the opportunity to clarify and amplify on your redirect examination. One question which is used on cross examination to confuse an inexperienced witness is, "Have you discussed the testimony you gave in this case with anyone before this trial?". The proper answer is, "Yes, with the State's Attorney and the Chief Investigator". Such discussions are perfectly proper and within the law. Although cross examination may on occasion become irritating and frustrating, the majority of attorneys no longer bluster and browbeat. If you do encounter one who uses such tactics, your best attitude is one of politeness and calm. Do not, become argumentative or angry and above all do not attempt to either outsmart or outshout the Defense Attorney. The State's Attorney is the one who is paid to do this. Conduct yourself along the lines suggested herein and your day in court will not be something to fear in advance or an ordeal when it happens.

CHAPTER IX

ADMINISTRATIVE PROCEDURES RELATING TO

INVESTIGATIVE PERSONNEL

Chapter IX

Administrative Procedures Relating to Investigative Personnel

I. Requesting Leave

All leave, annual, sick, personal, leave without pay and Military leave must be approved in advance by the Chief of Field Investigation by submitting form MDAC 71021. Whenever this is not possible such as in the case of an emergency illness or an emergency arising in an employee's personal affairs the employee's immediate supervisor should be advised of the circumstances. Upon return to duty it would be necessary to immediately complete a leave request (MDAC 71021) for post approval. See attached.

(See Employee Guide - State of Maryland, Dept. of Personnel pages 5, 6 and 7.)

Following is a discussion of various types of leave and the use thereof:

A. Annual Leave

Annual leave is the term used in the State for paid vacation. The number of days you receive each year depends on years in State Service.

New employees are credited with five days annual leave after 6 months of service. After 6 months you receive a little less than 1 day per month for a total of 10 days after 1 year of service.

See Employees Guide page 5 for additional information.

B. Sick Leave

Sick leave is a privilege and is to be used only for illness and/or accidents. Abuse of this privilege will not be tolerated.

Each employee receives 15 days of sick leave per year. This leave accumulates at the rate of 2½ days per month and accumulation is unlimited.

If sick leave is for 3 consecutive days or more a doctor's certificate is required. Sick leave, not to exceed five days, may be taken in the event of a death in an

employee's immediate family (Spouse, Parents, Parents of Spouse, Children, Sister or Brother of employee or Spouse).

As previously stated, abuse of sick leave will not be tolerated. The following policy has been established in this regard:

1. First, second and third occurrences of sick leave. Your supervisor will inquire as to the nature of your illnesses, to determine if they are work-related, and will counsel you against possible unjustified use of sick leave.

2. Fourth occurrence of sick leave. You will again be counseled by your supervisor, who will be required to record whether or not the illness is evidence of a recurring medical problem. You will be asked to justify your absences, with recommendations being agreed upon to alleviate the problem. This counseling session will be written up and you will be asked to sign it.

3. Fifth occurrence of sick leave. You will be referred to the program director or division director where you work, who will counsel you as to your continued use of sick leave. He will decide what action need be taken at this time, if any. This interview will be written up, and you will be asked to sign it.

4. Sixth occurrence of sick leave. You will be referred to the Attendance Control Officer, who will take any appropriate action which is warranted by your complete record. You also may be required to present a doctor's certificate to authenticate all illnesses of one day or more.

5. Ninth occurrence of sick leave. You may be suspended, and you may receive a rating of Unsatisfactory in Work Habits on your annual efficiency report unless a doctor's certificate is on file which satisfactorily explains a chronic condition necessitating such absences.

6. Eleventh occurrence of sick leave. Further suspensions may be imposed, and you may receive an Unsatisfactory rating in Work Quantity, Work Habits, and Overall Efficiency. Also, if you are due to receive one, your annual pay increment may be deferred or denied.

7. Twelfth occurrence of sick leave. Charges may be placed with the Department of Personnel to remove you from State service.

C. Personal Leave

Each employee is entitled to three days leave for personal reasons in each calendar year. This leave may be used at any time upon employment in units not less than ½ day. Unused personal leave may not be accumulated and carried over into another calendar year.

D. Leave Without Pay

An extended period of leave can be authorized for the convenience of the employee, if he does not have annual or personal leave available, which is classified as leave without pay (LAW). This type of leave can be authorized not to exceed 30 days. LAW in excess of 30 days may be granted upon the recommendation of the Department head and upon approval of the Secretary of Personnel.

E. Military Leave

This leave with pay not to exceed 15 days may be granted by the Department head for the purpose of allowing the employee to perform his annual tour of duty for training with the Armed Forces. This type of leave cannot be charged to any other type leave. If Military leave of more than 15 days is needed LAW can be authorized for any days over 15 upon request, by the Secretary of Personnel.

II. Preparation and Submitting of Daily Reports

Each investigative employee must submit a daily report of his activities (see attached form).

This form is self explanatory and should be submitted at end of work day to the Chief of Field Investigation or by 8:30 a.m. of the next day.

Be sure to include "in office" activity as well as "out of office". Be accurate in recording milage on State car as well as private car. Designate opposite milage whether this was milage on State or privately owned automobile. The word "State" or "Private" is sufficient.

Any incidental expenses accrued on date of daily report such as parking, tolls, meals, etc. must be shown opposite "Expenses". Any leave taken during the day should be recorded opposite "Leave taken" with type of leave taken. If on leave for one day also submit daily report for that day upon your return to duty. If leave for 2 or more days, date your daily report from date of 1st day of leave to last day of leave. Example: You are on leave 5 days - submit one report dated 6/1-5/75 with type of leave taken recorded thereon.

III. Submitting of Expense Voucher and Use of State and Private Owned Automobiles on Official Business

All investigative employee's submitting expense vouchers should become extremely knowledgeable with the Departmental Procedures for detailed instructions pertaining to submission of expense reports (attached), titled "Policy on Travel and the Reimbursement of Travel Expenses" dated 6/30/72.

Expense vouchers should be submitted monthly to your immediate supervisor and should be submitted on the last working day of each month. (Page 7, Section VIII F of the Policy on Travel and the Reimbursement of Travel Expenses states that Expense Reports to be submitted weekly. Page 9, Section XI sets forth Privileges of Supervisors and Chiefs. Director, Medical Assistance Compliance Administration has directed the submission of the expense report on a monthly basis.)

Mileage reimbursement for private car use on official business will be at the rate of $.12 per mile.

By Memorandum dated May 19, 1973 new maximum meal allowances for all personnel was issued by the Director of Administration. These allowances are:

Breakfast	-	$2.00
Lunch	-	2.50
Dinner	-	7.50

Attached is a sample expense report.

Any employee utilizing a State or private automobile must be completely familiar with the Department of Health and Mental Hygiene policy as set forth in the attached titled "Policy on Travel and the Reimbursement of Travel Expenses" issued June 30, 1972, under headings II - State Owned Vehicles or State Leased Vehicles and III - Privately Owned Vehicles.

Any employee desiring to use a State automobile should clear through the Chief of Field Investigation and if possible make your request in advance. When using a State vehicle be sure to fill the gas tank if the gauge shows ½ or less.

IV. Recording Attendance (Sign-in and Sign-out register)

An attendance register is maintained by each Administration (usually on Administration Director's Secretary's desk).

When arriving for work in the morning initial next to your name and record time of arrival. When leaving after day's work record correct time of departure.

For recording compensatory leave and absence from work, review instructions on back of "Sign-in/Sign-out" record attached.

V. Long Distance and Local Telephone Calls

A. Long Distance

All long distance telephone calls should be cleared through the Chief of Field Investigation or his designated representative and should be held to a minimum.

Telephone calls to the Washington Metropolitan District can be dialed direct after dialing 112 and receiving a new dial tone. Calls to Baltimore from Washington Metro. District can be made by dialing 779-3650 and asking operator for extension desired.

B. Local Calls

All local calls from phones in the O'Conor building should be for official business only, except in an emergency.

Local calls can be made by dialing 9. There is no change in the dial tone and the number desired can be dialed immediately.

State of Maryland

OFFICE OF THE SECRETARY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
301 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301 • 383-3010

Neil Solomon, M.D., Ph.D., Secretary

TITLE: POLICY ON TRAVEL AND THE REIMBURSEMENT OF TRAVEL EXPENSES

I - GENERAL

A. Officials and employees traveling on official business are instructed to exercise the same care incurring expenses that they would if traveling on personal business and at their own expense. Since excessive and unnecessary travel and other expenses will not be approved or reimbursed, officials and employees are cautioned to plan their travel routes so that the minimum amount of travel will be involved with the maximum amount of inspections, field service or other activities. Expenditures for official travel will be considered as reimbursable if they are incurred in accordance with the standards herein set forth. These regulations are intended to cover most travel requirements which may arise in the normal operation of the Department of Health and Mental Hygiene.

B. The following rules and regulations apply to all members of boards and commissions and to all other officials and employees of the Department of Health and Mental Hygiene when engaged in official business.

C. Employees and officials earning either cash overtime or compensatory time and meeting the requirements of being on official travel status are eligible for meal reimbursement.

D. The first thirty (30) minutes of travel and the last thirty (30) minutes of travel will be considered as normal commuting time for the purpose of computing compensatory time earned and/or overtime while on travel status.

II - STATE-OWNED VEHICLES OR STATE LEASED VEHICLES

A. State vehicles are to be used for official assignments only. All personnel before driving a State owned or State leased vehicle must read the "General Rules for Drivers of State-Owned Vehicles" promulgated by the Department of Budget and Fiscal Planning and sign an acknowledgment that he (she) has read them.

B. State vehicles are to be used for work assignments while carrying out official business wherever possible. Officials or employees who do not have a car assigned to them personally should attempt to use the car(s) assigned to their unit, personnel of their unit or their institution motor pool.

Issued 6/30/72

C. Persons driving State vehicles must possess an operator's license which is valid in the State of Maryland.

D. State vehicles are not to be used for out-of-state travel except:

1 - Where the official or employee frequently must conduct Department business in other states for which he has approval of the Chief of his division or his supervisor.

2 - For trips to Washington, D. C. and H.E.W. Regional Headquarters.

3 - When it is convenient and/or less expensive for a group to travel together to other than a border state in one car.

4 - Where the destination is not adequately served by public transportation.

5 - When the employee is required to move about extensively in the destination area.

6 - Where the use of a State car would result in savings of substantial time or of money.

E. Any accident involving a State owned, State leased or a privately owned vehicle on State business must be reported within 48 hours to the Safety Coordinator, Division of Support Services, DHMH. Personnel attached to or driving vehicles attached to Headquarters, DHMH (State tags) will send in 6 copies of form "Maryland Motor Vehicle Accident Report" (FR 30) and 1 copy of form "Motor Vehicle Accident Investigation Guide" (FS 1) completely filled out. Personnel attached to or driving state cars attached to County Offices (Star tags) will send in 6 copies of form "Maryland Motor Vehicle Accident Report" (FR 30) only. Personnel attached to or driving state cars attached to the Department of Juvenile Services or Institutions of the Department of Health and Mental Hygiene will send in 1 copy of form FR 30 and FS 1.

The Safety Coordinator, Division of Support Services; the Department of Juvenile Services and the individual Institutions, DHMH will send 3 copies of form FR 30 to the Office of the State Treasurer and 1 copy of form FR 30 to the Department of Budget and Fiscal Planning and retain a minimum of 1 copy of form FR 30 and FS 1 for their own files.

All forms pertaining to a vehicle leased by the State should be marked "LEASED VEHICLE." All forms pertaining to a privately owned vehicle should be marked "NON-STATE OWNED VEHICLE." All accidents will be reviewed by the Accident Review Board. The operator of the State vehicle may be charged for any damage that occurs to a State vehicle because of the operator's negligence.

F. The settlement of any fine or penalty imposed for traffic or other violations relating to the use or operation of State vehicles is the responsibility of the individual concerned. The State will not pay or reimburse any cost involved or take any action for the abatement of such fine or penalty.

G. Reimbursements shall be made for the expense of overnight parking at hotels, airports, and parking lots, for day parking and for ferry, bridge and road tolls.

H. Operators of State-owned or leased vehicles must make the proper entries on the "State-Owned Motor Vehicles Daily Travel Log" form and the "Monthly Mileage Report" form (DHMH 754). One copy of "State-owned Motor Vehicles Daily Travel Log" and two copies of the "Monthly Mileage Report" are to be submitted by the fifth working day of the month following the month being reported to Support Services, Department of Health and Mental Hygiene.

I. Employees or officials should travel routes resulting in the greatest savings in cost and time.

J. The official or employee using a State-owned or leased vehicle is responsible for the vehicle's proper care, servicing, operation and maintenance in accordance with the rules and regulations set forth by the Division of Support Services, the Department of Health and Mental Hygiene, the Department of Budget and Fiscal Planning, the lessor and the manufacturer. Should damage result through negligence, misuse or abuse, the operator may be charged for such damage.

K. Under no circumstances shall a State Service Station credit card be left in the custody of a service station, service station attendant or any other purveyor of material or service. The State credit card will only be used for maintenance and operation of the State car.

III - PRIVATELY OWNED VEHICLES

A. Privately owned vehicles, when used in conducting official business, will be governed by the policies in Section II, paragraphs C, D, E, F, G, and I above. The liability insurance of the State of Maryland will provide liability coverage, up to the limit of the State insurance policy, to drivers and/or owners of privately owned vehicles on official State business if liability should exceed the owner's and/or operator's private insurance.

B. An employee or official who is involved in an accident while riding in a privately owned vehicle while on official State business will look to the vehicle owner's and/or operator's private insurance company for "initial" loss recovery for personal injury and related medical claims. However, all State employees who are occupants of the vehicle and on official State business would also be covered under "Workmen's Compensation" (State Accident Fund) in case of injuries.

All loss suffered because of damages to the vehicle would be the responsibility of the owner, operator and/or insurance company of the owner and/or operator. The State of Maryland will not be responsible for damages to the vehicle.

C. Mileage reimbursement for private car use on official business will be at the rate of $~~.10~~ .12 per mile as fixed by the Board of Public Works without regard to the number of passengers carried.

1 - Reimbursement will not be for commuting distance, i.e., uninterrupted travel to or from the employee's normal work station or stations and home.

2 - Official business stops from home to field or vice versa can be claimed for reimbursement.

D. Mileage shall mean the distance from the employee's starting point to his destination and return or from his starting point to his destination to his current place of employment in case of a field trip; or the distance from his current place of employment to his destination and return, whichever is less.

IV - PUBLIC TRANSPORTATION

A. When an employee or official uses public transportation, travel shall be by the most direct route. Only side trips for official business will be permitted.

B. Actual fare for transportation by public carrier shall be reimbursed. Round-trip tickets shall be used when such use results in a saving.

C. When traveling by plane, tourist class tickets shall be obtained whenever possible. The cost of transportation to and from the airport shall be allowed. The cost of flight insurance up to $5.00 shall be allowed. Friendship Airport or any other State of Maryland Airport should be used whenever possible.

D. When traveling by train, coach rates shall be used unless the trip is overnight. If the trip involves overnight travel, pullman fare shall be allowed.

E. Porter fees of 50¢ per bag will be reimbursed.

F. Taxi fares to and from railroad or bus stations will be allowed.

G. Streetcar, bus and taxi fares are reimbursable only when incurred on official duty. Tips of 20¢ or 15% of the fare may be claimed for those modes of travel where the practice of tipping is customary and usual.

V - OTHER EXPENSES

A. Hotel bills will be reimbursed on the basis of actual cost, provided that itemized receipted bills are submitted with the expense voucher. Care must be taken to assure that the bill covers only the expense of the employee, and does not include expenses of the employee's spouse and family, or other nonallowable expenses.

B. When checking into a hotel, tip is reimbursable to the extent of fifty cents (50¢). The same tip is allowable when checking out.

C. Telephone and postage expenses incurred in the performance of official duties are allowable.

D. When an official or employee is required to be on travel status for a period exceeding seven (7) days, the cost of laundry, cleaning and pressing may be allowed.

E. When lodging and meals are obtained under the "American Plan," a receipt covering the full amount must accompany the expense account. Reimbursement may not exceed $45.00 per day.

VI - OUT-OF-STATE TRAVEL, IN-STATE TRAVEL, CONVENTIONS, MEETINGS, ETC.

A. The Secretary of Health and Mental Hygiene or his designee must approve all requests for out-of-state travel expenses in connection with attendance at conferences, conventions, seminars, meetings, etc., subject to amounts budgeted in Object .04 except for trips as explained below:

1 - Where the official or employee must conduct Department business in other states for which he has approval of the Chief of his division or the Chief's designee and will not be gone overnight. If travel requires an official or employee to be out of State overnight, approval must be obtained as outlined below.

2 - For trips to Washington, D. C. and H.E.W. Regional Headquarters for which the employee has the approval of the Chief of his division or the Chief's designee and will not be gone overnight. If travel requires an official or employee to be out of State overnight, approval must be obtained as outlined below.

B. All travel outside the United States and its territories and Canada must be submitted for approval to the Board of Public Works through the Secretary of Budget and Fiscal Planning over the signature of the Secretary of Health and Mental Hygiene or his designee. Under no circumstances will requests for approval of the Board of Public Works be sent direct to the Board or to the Department of Budget and Fiscal Planning.

C. The Chief of the Division or his designee must approve all in-state travel and expenses, including overnight lodging, in connection with routine State of Maryland business (i.e., Auditing, Medical Services, Inspecting, etc.), subject to amounts authorized in the budget.

D. The Secretary of Health and Mental Hygiene or his designee must approve all requests for in-state travel and expenses in connection with attendance at conferences, conventions, seminars, meetings, etc., when the official or employee is to be away from home overnight, subject to amounts authorized in the budget.

E. All travel directly connected with the training of State employees requiring attendance at any conference, seminar or training course which exceeds one week must be submitted to the Board of Public Works through the Secretary of Personnel and Secretary of Budget and Fiscal Planning over the signature of the Secretary of Health and Mental Hygiene or his designee. Under no circumstances will requests for approval of the Board of Public Works be sent direct to the Board or to the Department of Personnel or to the Department of Budget and Fiscal Planning.

F. Department of Health and Mental Hygiene form DHMH 14, until exhausted, or Comptroller of the Treasury form GAD Form X-3 will be used to request approval for out-of-state travel as explained above and in-state travel in connection with attendance at conferences, conventions, seminars, meetings, etc., when the official or employee is to be away from home overnight.

G. One copy of the approved form DHMH 14 or GAD Form X-3 must accompany all requests for reimbursements for out-of-state travel.

H. Registration fees charged employees participating in a meeting are reimbursable. The receipt for the fee paid must be submitted with the request for reimbursement of expense.

I. The Secretary of Health and Mental Hygiene or his designee on or about the 1st of January and the 1st of July of every year will provide a list to the Department of Budget and Fiscal Planning of the names, titles, destinations, purposes of travel, and costs of all employees who have traveled out of State during the preceding six months.

VII - MEALS

The cost of meals is reimbursable, in accordance with the schedules set forth in paragraph I below, when incurred under the following circumstances:

A. When an official or employee is on travel status involving absence from home overnight, all meals are reimbursable.

B. The cost of breakfast up to the maximum allowed is reimbursable when an official or employee is required to leave home on official business two hours or more plus his normal commuting time prior to the beginning time of his normal place of business and only if the expense is actually incurred.

C. The cost of dinner, up to the maximum allowed, is reimbursable when an official or employee cannot get home within two hours plus his normal commuting time after the quitting time of his normal place of business and only if the expense is actually incurred.

D. No reimbursement may be made for the cost of alcoholic beverages.

E. Should a physician, psychologist or any other personnel be assigned to provide a service on a shift basis and be expected to be working during the dinner or breakfast hour, dinner or breakfast cannot be claimed.

F. No reimbursement for either breakfast or dinner will be made because of the hour at which an employee is required to leave home, or at which he returns home because of commuting to and from his normal place or places of employment.

G. Where a State institution, as a matter of practice, charges an employee for meals, regardless of whether or not the employee eats a particular meal, and such employee is required to be absent from the institution

on official duty at meal time, he shall be reimbursed to the extent of the cost of the meal charged to him by the institution.

H. Except as provided in Subsections A and G above and the note below, no official or employee shall be reimbursed for the cost of luncheon.

I. Schedules of reimbursable rates for meals (including tips) are:

[redacted] $2.00 Breakfast
[redacted] 2.50 Lunch
[redacted] 7.50 Dinner

These rates are applicable for travel both within the State of Maryland and out of the State of Maryland.

When lodging and meals are obtained under the "American Plan," a receipt covering the full amount must accompany the expense account. Reimbursement may not exceed $45.00 per day.

Note: When an official or employee is attending a meeting, seminar or convention, at which the cost of any meal is part of the cost of attending such affair, the cost of the meal shall be reimbursable to the official or employee.

VIII - REIMBURSEMENTS

A. Only actual expenses incurred, up to the maximums allowed, are reimbursable, claims for extraordinary amounts will not be honored.

B. Reimbursements will be allowed only for meals consumed by officials or employees of the State of Maryland and not by their guests.

C. Reimbursement will be made by the Comptroller in accordance with these travel regulations and when the request for reimbursement is submitted on the approved Department of Health and Mental Hygiene Expense Report (Form DHMH 1). The unit and project number of the official and/or employee must be included on all documents.

D. Invoices or other supporting data for hotel, travel fare, registration fees, etc., must be submitted with the expense account. Credit card charge tickets will not be sufficient. Taxi fares, bridge tolls (if not obtainable), tips, telephone charges and the cost of meals are exempt from invoicing requirements.

E. A separate Expense Report form must be submitted for each person seeking reimbursement.

F. Expense Report forms should be submitted weekly, or if for inconsequential amounts, when a combined total of $5.00 is reached.

IX - RESPONSIBILITY OF THE OFFICIAL OR EMPLOYEE WHO IS TO TRAVEL

A. The official or employee who is to travel must request approval in the manner as prescribed below:

1 - For in-state travel and expense in connection with routine State of Maryland business, approval must be requested of the Chief of the Division or his designee.

2 - For in-state travel and expense in connection with attendance at conferences, conventions, seminars, meetings, etc., when overnight stay is involved approval must be requested from the Director of Fiscal Administration through the Chief of the Division, through his superior on form DHMH 14 (until supply of form is exhausted) or Comptroller of the Treasury form GAD Form X3. The request must be at least fifteen (15) working days in advance of the trip and will be submitted in quadruplicate.

3 - For out-of-state travel and expense except as noted in Section VI A above, approval must be requested from the Director of Fiscal Administration through the Chief of the Division through his superior on Form DHMH 14 (until supply of form is exhausted), or Comptroller of the Treasury form GAD Form X3. The request must be at least fifteen (15) working days in advance of the trip and will be submitted in quadruplicate.

4 - For travel outside the United States and its territories and Canada and for the expense involved approval must be requested from the Board of Public Works through the Department of Budget and Fiscal Planning from the Chief of the Division, his superior and the Director of Fiscal Administration, DHMH. The request will be on form DHMH 14 (until supply of the form is exhausted) or Comptroller of the Treasury form GAD Form X3. The request must be at least thirty-five (35) working days in advance of the trip and will be submitted in sextuplicate.

5 - For travel and expenses directly connected with training, requiring attendance at any conference, seminar or training course which exceeds one week, approval must be requested from the Board of Public Works through the Department of Personnel and the Department of Budget and Fiscal Planning from the Chief of the Division, his superior and the Director of Fiscal Administration, DHMH. The request will be on form DHMH 14 (until supply of form is exhausted) or Comptroller of the Treasury form GAD Form X3. The request must be at least thirty-five (35) working days in advance of the trip and will be submitted in sextuplicate.

B. The official or employee will give one (1) copy of the approved form to his superior for filing in his division's files.

X - RESPONSIBILITY OF THE DIRECTOR OF FISCAL ADMINISTRATION

A. The Director of Fiscal Administration, as the designee of the Secretary of Health and Mental Hygiene, will:

1 - Review all applications for travel that need his approval as outlined above.

2 - Return all disapproved applications to applicant.

3 - Forward for approval to the Board of Public Works through the proper Department(s) all applications that need further approval.

4 - Return two copies of the approved application to the applicant.

5 - If applicant is a member of a "Self-Contained Accounting Unit" send one copy of the approved application to the accounting department of his unit.

6 - If applicant is NOT a member of a "Self-Contained Accounting Unit" send one copy of the approved request to Expense Desk; General Accounting Service; Division of Fiscal Services, Headquarters, Department of Health and Mental Hygiene.

7 - Keep a file of all approved applications.

8 - Prepare the semi-annual report of the names, titles, destinations, purposes of travel and costs of all employees who have traveled out of the State during the preceding six months and submit the report to the Department of Budget and Fiscal Planning.

XI - PRIVILEGES OF SUPERVISORS AND CHIEFS

A. Supervisors and Chiefs of Units may augment this policy by the promulgation of rules and regulations to control the flow of paper within their own unit(s).

NAME (PRINT): JOHN J. JOHN

VEHICLE LICENSE NO. GXO 765

ASSIGNED ☐
POOL ☐
PRIVATE ☒

PRIVATELY OWNED VEHICLES ONLY

DATE	SPEEDOMETER READINGS START	SPEEDOMETER READINGS FINISH	MILES TRAVELED
5/7	26504	26606	102
5/12	26720	26795	75
5/20	27005	27110	105
TOTAL MILEAGE			282

NOTE: REFER TO DEPARTMENTAL PROCEDURE FOR DETAILED INSTRUCTIONS PERTAINING TO SUBMISSION OF EXPENSE REPORTS.

DHMH – 1 (Rev. 11/70)

NAME (PRINT)	JOHN J. JOHN
SOCIAL SEC. NO.	267-58-4672
ADDRESS	659 W 27TH STREET - APT. 5
CITY, STATE	BALTIMORE, MD ZIP 21211
COUNTY OR UNIT	DIVISION OF FIELD INVESTIGATION PROJECT 0505-02

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
EXPENSE REPORT

FROM 5 / 1 / 75 (MO / DAY / YR) THRU 5 / 30 / 75 (MO / DAY / YR)

I hereby certify that all expenditures listed hereon are true and correct and were necessary and reasonable to accomplish the objectives of the trip.

SIGNATURE John J. John DATE 5/30/75

DATE	Mileage ($) Parking Taxi	Breakfast Lunch Dinner	Hotel or Motel	Air Rail Bus Fare	TOLL		DAILY TOTAL	EXPLANATION OF EXPENSE AND/OR PURPOSE OF TRAVEL
5/7	M $12.24	B		A			$12.24	OFFICIAL BUSINESS FIELD INVESTIGATIONS
	P	L		R				
	T	D		B				
5/12	M $9.00	B		A			9.00	OB FIELD INVESTIGATIONS
	P	L		R				
	T	D		B				
5/20	M $12.60	B		A	$.50		13.10	OB FIELD INVESTIGATIONS
	P	L		R				
	T	D		B				
5/21	M	B		A			.30	OB FIELD INVESTIGATIONS
	P	L		R				
	T	D		B $.30				
	M	B		A				
	P	L		R				
	T	D		B				
	M	B		A				
	P	L		R				
	T	D		B				
	M	B		A				
	P	L		R				
	T	D		B				
	$ 33.84	$	$	$ .30	$ .50	$	$ 34.64	TOTAL EXPENSES THIS FORM

PLUS	
EQUALS	$ 34.64
LESS	
EQUALS	$ 34.64

FROM ATTACHED SHEETS
TOTAL ALL EXPENSES
ADVANCE
TOTAL EXPENSES

FOR ACCOUNTING USE ONLY

FUND	PROG	OBJ	PROJ	ACT	ITEM	AMOUNT

APPROVED BY ____ DATE ____

PROCESSED BY ____ DATE ____

COMPTROLLER'S COPY

STATE OF MARYLAND

STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Sign - in / Sign - out

(a) DATE/NAME _____

(b) NAME/DATE	(c) Time In	(d) Time Out	TIME DETAIL (e)								REMARKS (f)
			Regular Time	O.T./Comp.		ABSENCE				Total Time Acctd. For	
				Auth.	Hours	Code	Hours	Code	Hours		

ABSENT "TYPE" CODES		
ANN. LV.-	Regular	10
	Tardiness	12
	Unreported	16
	Emergency	17
SICK LV.-	Regular	20
	Dr. & Dent.	21
	Maternity	22
	Per. Inj-Dty	23
	Family Death	24
	Extended	25
	Unreported	26
	Emergency	27
COMP.-	Regular	40
	Unreported	46
	Emergency	47
PERS.-	Regular	50
	Emergency	57
HOL.-	Regular	60
COURT-	Sub-Unpaid	70
	Jury	71
MAL ASLT-	Work Rel.	72
MILITARY LEAVE		74
STATE MERIT TESTING		75
TRAINING TIME		78
LAW-	Regular	80
	Unreported	86
DISC. SUSPENSION		90

DHMH 566 (Rev.)

(g) Supervisor's Signature

SIGN-IN/SIGN-OUT — DHMH 566

INSTRUCTIONS

NOTE: All entries must be in ink.

a. DATE/NAME: Enter Name if the sheet is to record data for one person. Enter Date if sheet is to be used for multiple Signees.

b. NAME/DATE: Enter one Date per line if sheet is to record data for one person. Enter one Name per line if the sheet is to be used by multiple Signees.

c. TIME IN: Enter the hour that the Day's work begins. (Employees signing in early for their own convenience shall not be entitled to overtime or compensatory credit.)

d. TIME OUT: Enter the hour that the Day's work ends. (Employees signing out late for their own convenience shall not be entitled to overtime or compensatory credit.)

e. TIME DETAIL:

REGULAR TIME: Enter Number of Regular Hours worked. Cannot exceed hours in a normal work day, i.e., 7.1 or 8.

OVERTIME OR COMPENSATORY: Enter the hour and tenths of hours of Overtime-Compensatory Time that have been earned for that day. See the chart below for conversion of minutes to tenths of an hour. If the credit is to be given for overtime or compensatory time, the Individual's supervisor must initial in the Authorization column. All overtime must be supported by a Daily Overtime Voucher (DHMH-36) attached to the Employee Time/Status Report.

ABSENCE: Enter the reason for the absence by code and the number of hours absent (hours and tenths of an hour). If more than two types of leave/absence are utilized on the same day, the additional codes and hours will be shown in the Remarks column, "f."

TOTAL TIME ACCOUNTED FOR: The sum of regular hours worked plus times entered in the Overtime/Compensatory and Absence columns.

f. REMARKS: Use to clarify other entries or use to record unusual events. Absences from the office on official business will be entered in this column. Employees working in a project other than their permanently assigned project will enter this fact in this column.

g. SUPERVISOR'S SIGNATURE: Supervisor will sign each sheet.

CODES: Codes are to be entered in the Absence or in the Remarks columns to indicate the reason for the absence.

CONVERSION CHART FOR MINUTES TO TENTHS OF AN HOUR:

6 Minutes = 0.1 Hour	36 Minutes = 0.6 Hour
12 Minutes = 0.2 Hour	42 Minutes = 0.7 Hour
18 Minutes = 0.3 Hour	48 Minutes = 0.8 Hour
24 Minutes = 0.4 Hour	54 Minutes = 0.9 Hour
30 Minutes = 0.5 Hour	

DAILY REPORT

Division of Field Investigation

Investigator: _____ Date: _____

Time From	To	Case Number	Kind of Activity

EXPENSES: LEAVE TAKEN:

MILEAGE: Start Finish

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3 8095 00014238 6